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ABSTRACT

This document consists of the two issues making up volume 2 of "The Journal of the Pennsylvania Counseling Association." The articles attempt to meet the interests and needs of those in various counseling fields such as counselor education, mental health, career, rehabilitation, and community or school counseling. Articles in the first issue include: "Professional Development Message from the Co-Editors" (Clifford W. Brooks, Jr. and Andrew L. Carey); "The Counseling/Learning Model Using Epistemological Theory in College Counseling" (Colette T. Dollarhide and Susan Scully); "Sick at School: The School Counselor and Psychosomatic Disorders" (Kurt L. Kraus, Anne M. Geroski, and Kevin A. Rodgers); "The Client Developed Daily Inventory: A Self-Directed Evaluation of Personal Performance and Experience" (Robert J. Chapman and Paul D. Borish); "Sarah's Story: Using Ritual Therapy to Address Psychospirutal Issues in Treating Survivors of Childhood Sexual Abuse" (Rahda J. Parker, H. Shelton Horton, Jr., and Terri Watson); and "Experimental Pre-Practicum Counselor Training" (Kevin A. Fall, Justin E. Levitov, and Maureen C. Jennings). Articles in the second issue include: "Increasing the Odds: How to Get Published in JPCA" (Andrew L. Carey and Clifford W. Brooks, Jr.); "Ethics, Philosophy, and Culture: Exploring the Issues Involved in the Spirituality-Religion-Counseling Debate" (Lance Evans); "Assisting Clients in the Cross-Cultural Adjustment of Counseling" (John McCarthy); and "Measuring Counselor Development with the Counselor Self-Efficacy Scale" (Christopher J. Quarto). (ADT)

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Volume 2 Numbers 1-2

Editors: Clifford W. Brooks and Andrew L. Carey

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Professional Development Message from the Co-Editors

Clifford W. Brooks, Jr.
Andrew L. Carey

Welcome to another issue of *The Journal of the Pennsylvania Counseling Association (JPCA)*. We encourage you to treat yourself to a little professional development. Often, we race from one task to another, trying to make a difference in this world. We give and give and give, and after a while, if we don't refill the tank, it either runs empty or it sputters ineffectively even though it is still running.

Reading this journal is professional development. Such reading is an important part of staying current and learning about what others in the field have learned through much time and investigation. We will develop most through this reading when we find ways to tie the learning to what we are most passionate or motivated about. As you read this issue, consider how the writers' points are applicable to your setting or population, and how any of the principles may be applicable to your areas of interest.

In addition, particular articles may stimulate ideas of your own that you may wish to contribute in a future issue. It is amazing how, in the actual writing of ideas, much clarity and direction results regardless of the particular topic. In essence, professional development rapidly occurs in the process of writing your ideas. For us, personally, we have recognized our growth at a practical level in certain areas because of writing about cetain topics. Writing clarifies and teaches a great deal to the writer much like preparing to teach does for the teacher.

Professional development is essential for you personally and for our profession. We urge you to consider submitting manuscripts for future issues of *JPCA*. At this time, we are most interested in practitioner oriented manuscripts. We will do our best to work with you to facilitate your own professional development and to bring about a polished product that will contribute meaningfully to the counseling field.

The Counseling/Learning Model: Using Epistemological Theory in College Counseling

Colette T. Dollarhide
Susan Scully

Counseling services on college campuses are under pressure to deal with funding cuts, to meet increasing client load with increasingly severe presenting problems, and to improve and document learning connections with the academic mission of the institution. To meet these challenges, college counselors will need new tools. This article proposes the use of epistemological theory as one new tool – with it, the counselor has a model of counseling that directly addresses the learning activity of the counseling relationship. An overview of epistemological theory is presented, a model of counseling/learning is outlined, and a counseling example is provided.

College counseling, often more a functional description than a job title, has evolved from three distinct philosophies: student personnel counseling, vocational counseling, and mental health counseling (Dean & Meadows, 1995). From the student personnel philosophy, college counseling has inherited a developmental focus. From the vocational counseling philosophy, college counseling has inherited the career, financial, and academic focus (Baker, 1993; Carney, Peterson & Moberg, 1990). From the mental health philosophy, college counseling has inherited a focus on personal and social counseling (Baker, 1993; Carney, et al., 1990).

The legacy of these perspectives is the expectation that college counseling centers will provide long-term therapy. However, funding for colleges is on a decline nationally (Lively, 1994), thus limiting resources for many college support services including resources needed to provide

long-term therapy. However, at the same time, counselors report an increase in the number and severity of presenting issues (Dean & Meadows, 1995; Sharf, 1989), which has led to studies of time-limited counseling (Bieschke, Bowan, Hopkins, Levine & McFadden, 1995; Bishop, 1995; Gage & Gyorky, 1990; May & Sowa, 1994), brief therapy (Steenbarger, 1992; Steenbarger, 1993; Turner, Valtierra, Talken, Miller & DeAnda, 1996), privatization (Phillips, Halstead & Carpenter, 1996), and fee-for-service (Bishop, 1995; Waehler, Hardin & Rogers, 1994).

The solution to the concurrent problems of declining resources and increasing numbers of students with increasingly severe presenting issues may be found in the student personnel counseling philosophy which emphasizes the relationship between student support services and academic experience. With escalating pressure on college campuses to justify their programs in light of declining resources (Dean & Meadows, 1995; Upcraft, 1994), campuses must be able to relate their student services programs to the educational mission of the institution; a strong connection must be made between campus services and the academic experience (Blimling & Alschuler, 1996; Dollarhide, 1995). This position has been stated most recently and emphatically in The Student Learning Imperative (American College Personnel Association, 1994), and has been a part of college student personnel philosophy statements for many years (National Association of Student Personnel Administrators, 1937, 1949, 1987).

This emphasis on the educational mission of the university and the focus on student development means that practitioners need to access new tools; practitioners need access to useful, usable theory (Upcraft, 1994). If education and learning is to be the lens through which counseling professionals view the college student/client, then learning theory becomes a valuable tool for the counseling practitioner practicing in the college context (King & Baxter Magolda, 1996; Stage, 1996).

This article will draw direct parallels between learning and counseling using epistemological development as a framework for the counseling process. A proven model for college counseling using an epistemological framework which provides a language for describing counseling as an academic activity will be presented. To assist the reader in conceptualizing this process, an example of the counseling process will be provided, illustrating the college counseling model.

Counseling is a Learning Activity

Counseling theories address the client and her/his relationships with self and others (Corey, 1996). Most theories, in an organismic context, a rationalistic context, or in a constructionistic context (Thomas, 1996), describe client movement toward greater autonomy and self-direction. The emerging theories of social constructionism/contextualism (Lyddon, 1995; Thomas, 1996) and multicultural counseling/therapy have expanded the definition of self and others in an attempt to increase "personal, family, group and organizational consciousness" (Cheatham, Ivey, Ivey, Pederson, Rigazio-DiGilio, Semek-Morgan & Sue, 1997; p. 192). In all of these theories, there is a strong psychoeducational function (Cheatham et al), a strong emphasis on greater awareness, self-direction and freedom of choice (Corey, 1996). Counselors need to recognize the direct parallels between this control over one's life and learning (Cheren, 1983). Counseling, at its foundation, is about change (Capuzzi & Gross, 1995); and "all theories of psychological change are fundamentally theories of learning, and all theories of learning ultimately entail a theory of knowing" (Mahoney, 1991, p. 26). Integral to counseling, then, is learning and knowing, making epistemological development an appropriate template to describe the learning that takes place in the counseling process.

Epistemological Development

There are many different types of learning theories (Kolb, 1981; MacKinnon-Slaney, 1994; Stage, 1996). For the purpose of this article, a synthesis of selected epistemological theories will be the framework. Epistemological theories describe the process of learning through an understanding of the relationship between knower and knowledge, "and is concerned with basic questions related to the origins, nature, limits, and validity of knowledge" (Lyddon, 1995, p. 579).

Epistemological theories describe cognitive growth (Perry, 1981), the evolution from a social self to a self-authorizing self (Fleck-Henderson & Kegan, 1989; Kegan, 1982; Kegan, 1994), women's ways of knowing and relating (Goldberger, Clinchy, Belenky & Tarule, 1987); the intimate relationship between learner and knowledge in adults (King & Kitchener, 1994), and dialectical thinking (Basseches, 1980; McAuliffe, 1993). Figure 1 presents an overview of the terms used by these authors to describe the various levels or stages of learning. These theories all present the consistent view that potential for change is maximized when a person moves from

dualistic, passing learning and thinking to dialectic, active participation in the learning process, in which tolerance for ambiguity increases and the search for personal answers results. The learner must be involved, must have sufficient structure, must be given feedback, must be able to apply the learning, and must be able to integrate new learning with existing schema (Schroeder & Hurst, 1996). Two conditions are necessary for learners to move from one learning condition to the next: support and challenge (Kegan, 1994).

These theorists propose that the most basic stage of intellectual development is dualism (King & Kitchener, 1994; Perry, 1981), in which the learner uses either/or, right-and-wrong, dichotomous thinking. In addition, the learner looks for an external authority to provide an absolute answer to questions of "good" versus "bad" which is viewed as ultimate truth. In order to progress to the next level, the learner needs sufficient structure to provide support, and sufficient challenge to promote involvement and investment in learning.

The second stage is the questioning of dualism, or process awareness (Perry, 1981), in which the learner begins to see that there are multiple ways to define "good" and "bad" (Golderberger et al., 1987; Perry). At this stage, the learner realizes that there are multiple authorities and multiple truths. In order to progress to the next level, the learner needs support in confronting ambiguity, and challenge to continue gathering alternative perspectives.

Multiplicity (Perry, 1981) or subjective knowledge (Goldberger et al., 1987) is the next stage, in which the learner loses awareness of those initial, anchoring definitions of "good" and "bad"; all viewpoints are seen as equally valid since no ultimate truth exists. At this point, learning involves overwhelming ambiguity. The learner needs support to wade through the ambiguity, and challenge to begin exploring personal answers and opinions.

The fourth stage, contextual relativism (Perry, 1981), consists of awareness in which appropriate choice depends upon the context of the choice; truth is relative to the personal context (as opposed to the social/political/economic context of the sixth stage) in which it is defined. Learning involves being able to move into and out of personal contexts to articulate relative shades of personal truth. Learners need sufficient support to take risks in expressing their own direction, and challenge to learn from self-defined erroneous conclusions.

Figure 1: Terms Used by Authors in Epistemological Development Theory

Note: Categories are placed relative to approximate development of greater self-awareness.

	Basseches 1980	Perry 1981	Kegan 1982	Goldberger et. al., 1987	MCAuliffe 1993	King & Kitchener, 1994
Stage 1		Dualism	Socializing Mind	Silence	Inter-Personal Dualism Balance	Pre-reflective thinking
Stage 2		Process Awareness		Received Knowledge		
Stage 3		Multiplicity		Subjective Knowledge		Quasi-reflective Thinking, Stage 4
Stage 4		Contextual Relativism		Procedural Knowledge		Quasi-reflective Thinking, Stage 5
Stage 5		Commitment	Self-Authorizing Mind	Constructed Knowledge	InstitutionalReflective Self	Thinking
Intra-Psychic Knowing						
Socially Constructed Knowing						
Stage 6	Dialectical (elements of both)				Interindividual Self	

At the fifth stage, commitment (Perry, 1981), self-authorizing (Kegan, 1994), constructed knowledge (Goldberger et al., 1987), or reflective thinking (King & Kitchener, 1994), the learner has access to his/her own voice and tolerance of intellectual ambiguity. This stage involves the ability to define and defend one's own intellectual discoveries; authority resides in the self-as-knower and in the ability to engage in procedures for testing one's own hypotheses. The learner needs support in dealing with conflicting feedback as a result of those discoveries, and challenge in learning not to rely on previous decisions and assumptions.

The final stage from a social constructionist perspective (Thomas, 1996), dialecticism (Basseches, 1980) or interindividual self (McAuliffe, 1993), allows the learner to see the continuum of personally constructed meaning in the social, political, and economic context in which it operates (Lyddon, 1995). At this stage, the learner is challenged to empower him/herself to "define ... problems contextually and consider both critical assessment of and active change in social conditions... that impede personal development" (Lyddon, 1995, p. 582).

Research into chronological maturation, educational attainment, and epistemological development reveals that these learning activities are evident in the college experience. Dualism is the most common mode of thinking when persons enter college, multiplicity is often developed through college, and commitment is often not achieved until graduate school (Baxter Magolda, 1990; King & Kitchener, 1994). Attainment of the sixth stage, dialecticism or interindividual self, can be hypothesized as being situationally determined, contingent upon whether a learner is empowered to see larger social contexts -- the "location of an element or phenomenon with the whole(s) of which it is a part" (Basseches, 1980, p. 36).

College students, therefore, are immersed in the challenge and ambiguity which precedes the transformation from one learning level to the next. However, the second prerequisite for intellectual growth–support–is often missing from classrooms (Bondeson, 1996). It is also during college that Anglo-American students are likely to encounter the experiences with diverse persons which precede systemic, sociodiversity awareness (Pascarella, Whitt, Nora, Edison, Hagedorn & Terezini, 1996; Terrell & Watson, 1996).

Counseling as Epistemological Development: The Counseling/Learning Model

In the learning milieu, the learner, with a balance of challenge and support, moves from an external locus of control and silence to an internal locus of control and social empowerment. In the counseling milieu, the client finds the challenge and support to progress through the stages of learning about self, other, and context. Effective counseling is contingent upon, and designed to provide, the same core conditions (Schroeder & Hurst, 1996) required for learning: involvement and investment in both the process and the outcome (Strong, 1968; Strong & Matross, 1973); structure in the relationship between counselor and client (Corey, 1996); feedback in the here-and-now in terms of relationship, process, and outcomes (Brammer & MacDonald, 1996); application of counseling insights in "real world" contexts (Corey 1996); and integration of new insights and behaviors into current functioning (Corey).

There are many variations of the stage models of the counseling process (e.g., Garcia, 1995; Waehler & Lenox, 1994), usually describing the actions of the counselor. In this proposed model, the focus is on the process of the client, providing the college counselor with language to describe the client's learning gains and access the lexicon of the academic environment. It is important to note that stage models have been criticized for imposing artificial distinctions on what is, in reality, a continuous process (Waehler & Lenox); this model would be applied in a flexible manner to allow the counselor to move through the continuum of counseling/learning activities as the client moves. It is also important to note that clients may enter counseling at any stage in their epistemological development. This means that counselors need to accurately assess and recognize the stages, identify the client's presenting stage, and then engage and support the client at whatever level the client presents. Counseling would then progress as the counselor assists the client to move toward greater levels of personal and contextual awareness as described in the model.

Dealing with Dualism: A client enters counseling looking for the answers to life's problems, asking the counselor for guidance, advice, and direction. In response, the counselor at this initial stage of counseling would provide support, a sense of safety, and sufficient challenge to encourage the client to examine areas in which the client does not take ownership of his/her decisions. Counselors would want to be especially careful not to provide solutions for the client, as dependency may be an issue at this stage.

Dealing with Emerging Process Awareness: The client at this stage has moved into the awareness that previously defined authorities have conflicting definitions of right and wrong. Trust is a critical issue for the student/client, since "expert" others (external authorities) have not provided consistent guidance about life's dilemmas. The relationship with the counselor may be strained as the client tests the expertness and trustworthiness (Strong, 1968; Strong & Matross, 1973) of the counselor while concurrently asking for advice and direction.

Dealing with Multiplicity: As the client becomes increasingly aware that there is no one absolute authority with ultimate truth, the client is overwhelmed with the enormity of finding his/her own options and owning the selection of the appropriate option(s). The counselor assists the client to understand the multiplicity of perspectives, providing support to discuss those and challenging the client to look within for answers.

Dealing with Contextual Relativism: The client at this stage will begin to see that there are situations in which self and others have chosen their own answers to define personal right and wrong. The counseling activity at this stage is focused on finding common themes in those situations in which the client found her/his own answers, and reinforcing discussion of personal contexts and tentative choices. The counselor continues to support discussion of options, and challenges the client to articulate personal contexts that predicate choice.

Moving into Commitment: The client begins to articulate his/her own answers to life's problems, and begins to express greater confidence in those answers. In this stage, the client often perceives that counseling is complete, since the "answer" is found. The counselor challenges the client to continue to examine his/her sources of knowing about life, to consider greater contextual awareness.

Moving into Socially Constructed Knowing: At the final stage of counseling, the client is aware of how she/he constructs reality and how social contexts can impede personal development. The client may also be self-empowered to act on behalf of change. "Because the concept of empowerment hinges on the interrelationship between the personal and the social, empowerment strategies encourage persons to define psychological problems contextually and consider both critical assessment of and active change in social conditions as viable therapeutic goals" (Lyddon, 1995, p. 582).

The following is an example of the counseling/learning model, demonstrating all of the above stages and illustrating the ebb-and-flow of epistemological progress. Melissa, a 24 year old Anglo-American woman, presented for counseling complaining of chronic dissatisfaction at work, inability to decide on a new professional direction, and problematic, short-term intimate relationships.

Dealing with Dualism: In the first session, Melissa shared that she majored in nursing because her parents and friends urged her to follow a "practical major"– one that guaranteed employment. She blamed those individuals for telling her to enter the "wrong" career and wanted the counselor to tell her what the "right" career is–one that guaranteed both employment and happiness. She indicated that it would take a lot for her to trust the counselor's advice and wanted the counselor to prove she had the expertise to deal with career issues. In terms of her personal relationships, Melissa was searching for a significant other who was "mature"–one who had answers to life's questions and around whom she could then build her world. She expressed doubt that she was capable of leading her own life without a stronger other to "anchor" her.

In this first session, the counselor shared this model of counseling with Melissa, explaining that she will be learning about herself and finding her own answers in the sessions. They agreed that the counseling would focus initially on the career issues with which Melissa was dealing, and that the personal relationship issues would be addressed after those career issues were resolved (since the counselor hypothesized that finding her own career answers would concurrently help Melissa articulate her own relationship answers). A firmly grounded counseling relationship was established, and the counselor shared that Melissa would find support for her journey in the counseling venue, but that she would also be challenged to examine how she saw others and herself in this process. Trust was discussed in terms of both Melissa's trust in the counselor as well as trust in herself throughout counseling.

Dealing with Emerging Process Awareness: As counseling progressed, Melissa shared the sources of her work dissatisfaction. She disliked her daily routine and activities, her co-workers, her employers, and her patients. As a means of introducing her to the process of finding her own answers, she was challenged to look at those she knows – friends, family or co-workers – to identify those who live as others tell them, and juxtapose those lives with persons who make their own choices. Which ones would she like to pattern

her life after? With support, Melissa explored the emptiness she saw in the lives of those persons who lived their lives based on the "truth" of others. She began to see the price these persons have paid for their surrender to the messages of society (i.e., acquisitiveness) or the messages of others (i.e., empty marriages, short-term relationships, workaholism) (Fox, 1994). Melissa was learning to question the voices of others and becoming aware of the need to make decisions for herself. She still needed support, however, in learning to hear her own voice (Goldberger et al., 1987).

Dealing with Multiplicity: Counseling continued, and her career concerns became a useful metaphor to help her learn to hear her own voice. Following a Lifecareer perspective (Miller-Tiedeman, 1988), the counselor asked Melissa to explore where her career path had brought her to date. She discussed how her choices had brought her to a sense of loss; she had no direction in life and asked for answers to the questions "Who am I? Where am I going?" She was learning to question herself.

Dealing with Contextual Relativism: The counselor then facilitated Melissa's awareness of herself as knower, encouraging her to give herself permission to explore all her options. The counselor prompted Melissa to generate many career ideas from her interests, and as a result, she gathered tremendous numbers of alternatives. Melissa was energized by the process of self-exploration and discovery, yet seemed intimidated by the enormity of her quest. She was learning to cope with ambiguity.

The counselor then challenged Melissa to find her own voice in the process of defining herself. Melissa expressed the desire to find a career in more scientific areas related to biology, and seemed intrigued with the idea of field biology. Since there were numerous wildlife refuges in the surrounding counties, she was encouraged when she conducted informational interviews and learned about opportunities for graduate students in wildlife biology. She learned about the classes she would need to take and how to apply for graduate school after taking the advanced biology series. She was learning to assess context in which to find her voice.

Moving into Commitment: As Melissa moved into commitment, she became empowered to make personal changes and moved toward closure of her professional plans to apply for graduate admissions in biology. She expressed optimism in her future, and through a review of her career decision process (Miller-Tiedeman, 1988), she expressed confidence that she could

navigate the same process the next time she desired new self-expression through work. She was learning about herself as a choice-maker, a self-authorized and reflective knower.

Moving into Socially Constructed Knowing: At the final session, the counselor asked her to reflect on the social milieu into which she was entering. Melissa shared that she was a little nervous that she was entering a professional area that was traditionally dominated by men. She expressed concern that there would be few role models and few mentors. The counselor shared some information about mentoring, including different mentoring models and processes, then they discussed the reality of being a woman in a traditionally male field. Melissa felt that she would need time to cement the learning she had experienced in counseling, but that she now believed herself better able to make decisions and stand up for her convictions. She believed that this would help her to face potential co-workers who might not see her as appropriate in their environment. The counselor discussed with her the reality of being immersed in a new environment: that she would be challenged to grow stronger or she could retreat back into silence. As a result, coping strategies were explored. The counselor also asked her to imagine in what ways she would change the professional environment; to her credit, Melissa shared her desire to help men in that field understand women better and her desire to mentor other women.

This led into a discussion of Melissa's relationships with persons of authority and men (since these are often perceived as the same; see Pipher, 1994). She had presented initially with complaints about relationships, wanting to find a mature man around whom she would focus her life. The counselor asks her to reflect on that presenting issue. What had she learned in the sessions that would impact that goal?

Again to her credit, Melissa expressed that she had had time to reflect on that goal. Now she was more interested in finding a relationship with someone who would see her as an equal, as a fully competent, fully functioning individual. As she developed and found her "voice", she no longer needed a mate to be her "anchor". She stated that she had learned a lot about herself and her future in counseling. Counseling was terminated at that point, and the counselor invited Melissa to return as her graduate degree progressed.

Conclusion

This model has been used successfully in a college setting, but results are anecdotal. As with the proposal of any new model, empirical research must be conducted to determine if there are issues, clients, and/or settings in which this model is more or less efficacious. Furthermore, it is felt that this model lends itself nicely to empiricism, as each level of the model can be clearly differentiated and recognized. For example, videotaped counseling sessions using this model could be compared to other models to examine externally and internally rated measures of support, challenge, and outcomes, and to track the movement through the levels. Other studies could examine the use of the counseling/learning model to determine efficacy relative to issues or client demographics.

College counseling, then, is more than an academic or student "service"; it is an encapsulated, concentrated learning activity, taking place in the learning environment that allows students to explore knowledge, self, relationships, and contexts. In appreciating the potential contribution counseling makes, it is no small wonder that out-of-classroom learning has been documented as being as meaningful as in-class learning (Pascarella, et al., 1996; Terezini, Pascarella, & Blimling, 1996). If used to its fullest learning potential, the counseling environment provides all six of the core conditions for learning (Schroeder & Hurst, 1996): involvement, structure, support, challenge, feedback, application, and integration. Furthermore, using this counseling/learning model provides structure for college counselors: the counseling activity has a distinct, definable learning objective which facilitates effective, goal-directed therapy (Morran, Kurpius, Brack & Brack, 1995). Implications for practice are numerous: counseling with this model would be more timely, thereby allowing counselors to work with more clients. This model teaches clients how to make their own decisions and find their own voice, thus empowering clients to solve problems independent of the counselor. Finally, it provides counseling professionals with language to describe the activity of counseling in educational terms, thus creating alliances with the academic function of the university.

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Sick at School: The School Counselor And Psychosomatic Disorders

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A thorough overview and a case study exemplifying the complexities and rewards of effective multidisciplinary intervention for children and adolescents with psychosomatic disorders are presented.

Mental and physical healthcare providers have long recognized how psychosocial and emotional factors can result in the development of physical symptoms. Classrooms are often the first non-home environments where young people display or voice such physical symptoms. Somatic complaints often propose numerous challenges for such children and adolescents as well as their teachers, school nurses, school counselors, their parents, and physicians and other health care providers. All too frequently, insufficient communication among so many concerned people results in exacerbation of symptoms. This seems especially true when emotional factors manifest as physical symptoms–the essence of psychosomatic disorders–for a young person in the school setting. Ultimately this lack of communication creates undo hardship for children who doubtless struggle with their numerous school absences, familial tension resulting from frequent complaints of being sick, and teacher concern and frustration. This article addresses three objectives: (a) to assist the school counselor in better understanding this common child and adolescent presenting problem; (b) to enhance the school counselor's means of effective communication with physicians and other non-school health care professionals; and, (c) to maximize the school counselor's success across multiple roles as counselor, coordinator, and consultant.

Symptoms, manifestations of an individual's condition, are produced in two ways, mentally or physically. Additionally, symptoms are subjective

perceptions of distress or illness. Psychogenic factors, thought to be caused or produced by mental processes, can induce or worsen organic disease states. Conversely, organic disease, especially in children, can often result in emotional problems. Given the complexity of interaction between biological and psychosocial factors, psychosomatic illnesses in children and adolescents, namely those health concerns better accounted for by mental processes than organic ones, are relatively common. Nemzer (1990) found that between 8% to 10% of outpatient pediatric visits were for some form of psychosomatic disorder. Other studies have shown the prevalence of the various psychosomatic disorders to range from 5% to 17% (Iezzi & Adams, 1993). A higher prevalence of psychosomatic disorders has been reported for females and for children from lower socioeconomic groups (American Psychiatric Association, 1994; Iezzi & Adams, 1993; Nemzer, 1990), and for children of parents with apparent somatoform disorders (Livingston, Witt, & Smith, 1995).

Throughout this article a brief case report affords school counselors an opportunity to see how one particular case, the case of Nathan (a pseudonym), emerges: how he is assessed through a multidisciplinary team approach, how the school counselor competently understood the complexities of Nathan's experience, and how the case ends--not with a "cure" but rather an ongoing plan that appropriately serves all those involved.

> Nathan is a 9-year-old boy in Ms. Langston's fourth grade classroom. Prior to this current school year, Nathan has had few absences from school, only occasional physical complaints, and minimal need for physician visits other than well-child check-ups. This year, though, has been markedly different. Nathan has missed 19 full days of school and has arrived late or has been dismissed early for a wide variety of complaints of abdominal distress (e.g., persistent nausea, abdominal cramping and bloating). According to his mother, an investment banker, Nathan's pediatrician has found no abnormalities in terms of medical evaluation at any of their seven visits over the previous six months. Nathan's school success, both academic and social, has plummeted. Tensions at home have grown, and mother, father, and 13-year-old sister are concerned, angry, and frustrated with Nathan. He swears he is "not faking" anything and certainly most of his symptoms do not seem feigned. Enormous stress is evident among all. The situation seems to be spiraling out of control; Nathan's physical and emotional well-being are worsening.

Numerous qualities often attributed to school counselors make them invaluable resources for effectively responding to children such as these. The school counselor is in the unique position of having specialized training and experience dealing with mental health issues as well as in collaborative assessment and intervention involving the emotional health of school-aged children (Baker, 1992; Geroski & Rodgers, 1998; Geroski, Rodgers, & Breen, 1997; see also Campbell & Dahir, 1997). The school counselor's work setting allows for timely, efficient information-gathering from students, parents, teachers, school nurses, and others. The school counselor is in a position to be a pivotal member of a collaborative "team" to perform initial assessment of children with inordinately frequent or persistent physical symptoms. The counselor in the school setting can then participate in collaborative mental health interventions.

For school counselors involved in such professional activities, it has been recognized as important to have familiarity with the terminology of the *Diagnostic and Statistical Manual, 4th Edition* (American Psychiatric Association, 1994), as this publication provides the common language for communication among physicians, psychologists, clinical social workers, and mental health counselors (Hohenshil, 1994; see Hume & Hohenshil, 1987).

> Ms. Rivera, the school counselor at Nathan's school, has seen Nathan several times throughout the first months of this school year. At these visits she expressed concern and has coordinated several parent teacher communications with regard to absences. Ms. Rivera has repeatedly extended an offer to Nathan and his mother to support both of them through this prolonged and difficult experience. In March, Ms. Rivera is contacted by Nathan's mother, "... He is sick so often that our doctor suggested we get in touch with a counselor. If it isn't physical then I guess it must be mental...I don't see how that can be. We need help! Maybe you can sort out what is going with Nathan and the rest of us. We are at wits end!"

The following section provides an overview and brief description of the *Diagnostic and Statistical Manual -IV* (American Psychiatric Association, 1994) diagnostic criteria for the various types of psychosomatic disorders commonly observed in children and adolescents, and considers the differential diagnosis of these types of disorders (i.e., other disorders which may overlap in terms of the symptoms the child reports or the behaviors that may be observed). Readers are encouraged to refer to the DSM-IV for a thorough

description of each disorder and additional information invaluable in helping adequately communicate among members of multidisciplinary professionals.

Psychosomatic Disorders

Somatoform Disorders

The common feature of the "somatoform disorders" as currently defined in the DSM-IV (American Psychiatric Association, 1994) is the presence of physical symptoms suggestive of a general medical condition and that cause significant distress or impairment in social or other function (such as academic). These symptoms, however, are not fully explained by the general medical condition or are not related to an existing general medical condition, are not under the voluntary control of the child or adolescent, and are not the result of substance abuse or of another psychological disorder. The DSM-IV does not consider factitious disorder or malingering as somatoform disorders, as these disorders involve report of physical symptoms that are under voluntary control. In factitious disorder the apparent motivation is to assume the sick role and to receive medical attention and treatment, while malingering has goals such as financial compensation, avoidance of duty, and evasion of punishment (American Psychiatric Association, 1994).

It is important to note that multiple physical symptoms may be the presenting manifestation of depression, anxiety, or adjustment disorders (American Psychiatric Association, 1994; Kronenberger, Laite, & LaClave, 1995; Lemma, 1996; Livingston, Witt, & Smith, 1995; Taylor, Szatmari, Boyle, & Offord, 1996). Such complaints may be suggestive of child abuse (Livingston, et al., 1995) or low self-esteem (Kronenberger, et al., 1995; Nemzer, 1990). It is also important to realize that for some adolescents, substantial concerns about their health combined with everyday bodily experiences (such as those arising from menstruation, transient changes in gastrointestinal changes related to diet, etc.) may raise concerns about potential loss of function and result in somatoform disorder (Taylor, et al., 1996).

Somatization disorder. The first major type of somatoform disorder is somatization disorder, which is characterized by a combination of pain, pseudoneurologic, gastrointestinal, and sexual symptoms. Often these symptoms have their onset by adolescence. The diagnostic criteria for this disorder are very specific in terms of types of symptoms, and the presence of the symptoms over the period of several years is required for diagnosis (American Psychiatric Association, 1994).

Undifferentiated Somatoform disorder. This diagnosis requires symptom duration of six months, and this diagnosis is often made for symptoms such as persistent nausea, fatigue, or gastrointestinal or genitourinary complaints. These symptoms are recognized as culturally shaped "idioms of distress" (American Psychiatric Association, 1994, p. 450) and are thought to represent a broad range of social or personal problems without implying psychopathology.

Conversion disorder. A final type of somatoform disorder sometimes encountered during childhood or adolescence is conversion disorder, which is characterized by neurologic symptoms such as loss of motor or sensory function typically to a specific area of the body and which usually does not involve specific complaints of pain. Conversion disorder usually has an initial onset after age 10, and typical manifestations are complaints of and behaviors suggestive of paralysis, blindness, seizures, tremor, or inability to speak (American Psychiatric Association, 1994). For children and adolescents with conversion symptoms, the presence of a family role model with like physical symptoms, family discord, early sexual trauma, and other psychosocial stress has been consistently reported (Iezzi & Adams, 1993).

Regardless of how or by whom the initial contact is made, Ms. Rivera first obtains a release of information from Nathan (such co-signature strengthens rapport and helps to build a strong relationship) and his mother to contact their family physician. Under the counselor's direction, additional information is gathered from current and prior classroom teachers, support staff, as well as a youth leader from Nathan's house of worship. The implicit goal being to have complete information from multiple sources in order to appropriately diagnose and implement an effective intervention plan (see Bennett Johnson & Rodrique, 1997). When gathered, the information is then compiled and shared judiciously among the parties. Information that is particularly critical initially is attendance patterns and antecedents to symptom onset. Also, awareness of natural consequences of repeated absence, early dismissal and late arrival for Nathan is needed. Attention to Nathan's strengths as well as perceived challenges is important. The physician is both supportive of the multidisciplinary collaboration and instrumental in ruling out any general medical conditions as the focus shifts from physical health to mental health. At this juncture, in Nathan's case, a clinical psychologist was hired to assess Nathan. Utilizing projective and standardized appraisal methods added to the overall understanding of Nathan's current health concerns.

Assessment

Typically, children manifesting somatic symptoms come to the attention of the school counselor from the school nurse, teachers, or parents with initial concerns or frustrations in regard to the frequent complaints of belly pain or headaches, or with concerns of poor school attendance (Greene & Thompson, 1984; see Fall, 1994). Because somatoform disorders challenge the expertise of both medical and mental health providers, collaborative and multidisciplinary assessment and treatment planning is necessary (Greene & Thompson, 1984; Lask & Fossom, 1989). The school counselor is in a key role to help parents understand the complexity of somatoform disorder, and to coordinate this assessment, working with a team of professionals including the school nurse or health center provider, the child's family physician or pediatrician, and other mental health providers.

The following guidelines may be helpful for the school counselor in the initial assessment of somatoform disorder and in clarifying the multiple roles and responsibilities of numerous team members.

Medical Evaluation. It is important for the school counselor to remember that while he or she may be encountering a child with early manifestations of somatoform disorder, much more common causes of physical complaints are often present. Medical conditions or psychosocial stressors such as those associated with adjustment disorders, depression, and anxiety are to be ruled out. By definition, for a child or adolescent to be diagnosed with a somatoform disorder, there must have been a medical evaluation to rule out a medical condition that could explain symptoms and impairment of function. The medical evaluation consists of taking an appropriate history of the illness, a physical exam, ordering relevant laboratory or imaging studies (e.g., blood or urine tests, x-rays, ultrasonic exams, etc.). Often, a key data set is the child's growth chart. In the event of persistent or recurrent abdominal pain, normal weight and height gain are reassuring and make significant organic pathology unlikely. The school counselor can facilitate this referral for medical evaluation if the child's parents desire this assistance. With appropriate written consent from parents, it would also be appropriate for the school counselor to communicate with the health care provider, giving information in regard to the child's symptoms, their duration, frequency, and effect on school and social function. This type of information can be very useful to clinicians in terms of arriving at an appropriate diagnosis, whether or not organic illness is present.

Psychosocial Assessment. Similarly, a complete psycho-social history is recommended for assessment and intervention planning. In most cases, the school counselor is able to perform an initial assessment of the current home environment (e.g., significant family change or loss, presence of drug or alcohol abuse, or child abuse or neglect), social adjustment, academic performance, and evidence of the presence of stress or features of other disorders. Shapiro and Rosenfeld (1987) suggest that interviews with child and parents be included in this assessment. With the child, the counselor (a) should explore the presenting problem by asking the child to describe the symptoms and the circumstances present when the symptoms are experienced; (b) his or her perception of how the somatic symptoms affect the child in his or her environment (i.e., school and home); and (c) his or her perceptions of what interventions helped alleviate the somatic symptoms in the past. It is important to remember that the use of confrontational approaches with individuals with conversion disorder are likely to exacerbate defenses and become counterproductive (Iezzi & Adams, 1993).

With the parents, the goal of the interview is to build a therapeutic alliance while gathering information. Important information needed from the parents includes a history of the onset and course of the symptoms, a description of the pre-morbid (i.e., prior to the occurrence of symptoms) personality of the child, behavior changes that may have accompanied the somatic symptoms, interventions that have been tried in the past, and parental perceptions of how the symptomology affects the family system (i.e., positive reinforcement). Their perceptions of whether there are any secondary gains to the child in regard to the somatic symptoms are important (Shapiro & Rosenfeld, 1987). Other important information that can be obtained from the parents include an assessment of the family functioning in the areas of adaptability, parental effectiveness, clarity of communication, decision making, problem solving, conflict resolution, and behaviors surrounding stress and illness (Lask & Fossom, 1989).

Psychological Assessment. A complete psychological evaluation is recommended as part of the initial assessment for psychosomatic disorders (Lask & Fossom, 1989; Shapiro & Rosenfeld, 1987; Sharpe, Peveler, & Mayou, 1992). This is particularly important in cases of severe somatic symptomology, complex comorbidity (e.g. somatoform disorders present concurrently with another disorder such as depression or anxiety) with other psychological symptoms, and when conversion symptoms are present. Beyond the psychosocial assessment, a psychological assessment would include a

comprehensive assessment in the areas of cognitive development, personality (Lask & Fossom, 1989; Shapiro & Rosenfeld, 1987) and an assessment of comorbid disorders, including an assessment of suicidal ideation (Sharpe, et al., 1992). Typically, the psychological assessment would be conducted using a clinical interview and projective and non-projective instruments (Lask & Fossom, 1989; Shapiro & Rosenfeld, 1987).

If a referral for this type of assessment is made to a professional outside of the school, the school counselor must receive parental consent for mutual exchange of information, and be prepared to provide information regarding social and academic functioning. Referral for outside assessment does not preclude the school counselor from being a part of the intervention planning; the school counselor can be a valuable member of the intervention plan for the child with somatic symptoms. Collaborative intervention among professionals is an important part of effective treatment (see Humes & Hohenshil, 1987).

While the multidisciplinary team is gathering information Ms. Rivera meets regularly with Nathan. With him, she also stays in close contact with his mother and father, the primary goal being to mediate additional stress and support all involved–validating the difficulties that Nathan's current health difficulties present. Ms. Rivera also meets periodically with Nathan's teacher. The counselor's consultation enables Ms. Langston to guard against potential blame of Nathan, and to focus on maximizing Nathan's academic productivity and social acceptance on days when he is able to be in school. In fact, such initial intervention seems to remediate some of the self-reported stress and family tension. Additionally, Ms. Rivera adapts her regular curriculum to incorporate stress reduction psychoeducation into her scheduled 4th grade classroom guidance meetings. This approach encourages both understanding of all childrens' stress management tools and normalizes Nathan's experience among his peers. The classroom becomes a place where Nathan's special needs are recognized without inadvertently pathologizing him, singling him out as the focus of classroom discussion, or ignoring the effect he may have on class members.

Concurrently, Ms. Rivera, initiates several other school-based interventions. These are school policy-directed and may differ from school system to school system. As a support person to Nathan's

mother and father, she contacts necessary personnel (e.g., Student Assistance Team, Special Education Department) enabling their resources to aid Nathan and his family. It is important to remind readers that school policies dictate protocol and in all cases such policy must be followed to ensure ethical and competent school counseling practice.

This next section is divided into two parts. First, a general literature review revealed a wide variety of individual and group interventions for use with individuals manifesting somatic symptoms. In some cases, multiple intervention strategies are advocated. Second, interventions most suitable for school counselors are presented.

Intervention

A wide variety of individual and group interventions have been used with individuals manifesting somatic symptoms, and in some cases, multiple intervention strategies are advocated. Intervention strategies should be based on the collaborative assessment of the client and intervention goals will vary with the individual client (Sharpe, Peveler, & Mayou, 1992). It has been suggested that the prognosis for individuals with somatoform disorders may be poor (American Psychiatric Association, 1994; Iezzi & Adams, 1993). However, the literature is abundant with reports that many individuals with somatic complaints do experience symptom remission after psychotherapeutic intervention (Kellner, 1986; Shapiro & Rosenfeld, 1987).

Insight-oriented and psychoeducational approaches emphasizing a strong client-therapist relationship are recommended for helping the client gain insight into the psychological factors inducing physical symptoms, and for helping him or her develop a cognitive understanding of the connection between physical symptomology and emotional stress (Lask & Fossom, 1989; Lemma, 1996; Nemzer, 1990). An emphasis on social skill development and exploration of issues of excessive dependency, over-protection, manipulation, power and control, and compliance are also recommended as important intervention goals (Nemzer, 1990). Psychodynamic approaches aimed at these treatment goals may be applied individually or in a group setting. The uses of play techniques such as non-directive play, art, sculpting, and psychodrama are recommended for work with children (Landreth, 1991; Lask & Fossom, 1989; see also Oaklander, 1978).

Cognitive-behavioral intervention strategies are also effective in the remission of somatic complaints (Mullins, Olson, & Chaney, 1992; Sharpe, Peveler, & Mayou, 1992). Central to the cognitive-behavioral approaches is the premise that the way the individual thinks about his or her bodily symptoms affects the continued presence of somatic symptoms. Cognitive techniques designed to correct dysfunctional thought patterns include helping the client assess his or her beliefs surrounding the somatic symptoms, and explore the related feelings and underlying assumptions surrounding the somatic symptoms. Typically, contracts and directive interventions are used to challenge dysfunctional beliefs and change the associated symptomatic behaviors (Sharpe, et al., 1992). Cognitive approaches are also used to help clients learn functional strategies for dealing with stress and more appropriate interpersonal and communication skills (Nemzer, 1990; Shapiro & Rosenfeld, 1987). Toward a similar end, behavioral techniques may be used, and include desensitization, flooding, reinforcement, modeling, shaping, and extinction (Lask & Fossom, 1989). Relaxation training and biofeedback have also been used to help individuals cope more functionally with anxiety and stress (Shapiro & Rosenfeld, 1987).

Family counseling is also recommended for intervention with children with somatic complaints (Lask & Fossom, 1989; Livingston, Witt, & Smith, 1995; Mullins, Olson, & Chaney, 1992; Nemzer, 1990). School counselors may find referral for such additional services well-received and highly beneficial for parents and other family members. Goals of family counseling may include helping the family system recognize patterns of enmeshment, overprotection, rigidity, conflict avoidance, inconsistent parenting, dysfunctional communication; (Lask & Fossom, 1989; Nemzer, 1990), and identifying other family members manifesting similar somatic behaviors (Livingston, et al., 1995). Other techniques that are helpful in working with parents include psychoeducation, support, encouragement, providing the opportunity for ventilation (Livingston, et al.), parenting skills, and strategies that help the family learn functional modes of communication and expression of feelings (Lask & Fossom, 1989).

Although the use of medication should be limited in the treatment of psychosomatic symptoms (Shapiro & Rosenfeld, 1987; Sharpe, Peveler, & Mayou, 1992), it should be recalled that for many individuals, psychosomatic symptomology is comorbid with depression, anxiety, or adjustment disorders. For individuals who may also have symptomology of these related conditions, efficacious intervention may include the use of psychotropic medication such

as an anti-depressant (Kellner, 1986; Lask & Fossom, 1989; Shapiro & Rosenfeld, 1987). Lask and Fossom caution that the use of medication should be considered only after a complete assessment, be used in connection to clearly defined treatment goals and with a specified length of treatment, with consent and cooperation of parents, and in connection with other treatment strategies.

The result of the multidisciplinary assessment for Nathan yielded a medical diagnosis of undifferentiated somatoform disorder (American Psychiatric Association, 1994, DSM IV [Axis I: 300.81], p.450). Beyond the benefit of more fully understanding this complex presentation of symptoms, the definitive diagnosis was relieving to both Nathan and his parents and sister. It was mutually agreed that Nathan would likely best respond if referred to a mental health professional outside the school–one who is well skilled and known for working in close conjunction with the other constituent members (e.g., the school team and the physician) of the treatment team.

Ms. Rivera continued to accept responsibility for coordination of the multidisciplinary team. She maintained contact with Nathan individually in a supportive role and continues to consult with both school personnel and Nathan's family. Continuing her school-based information collection aids in Nathan's treatment; everyone is fully knowledgeable--within the ethical boundaries of confidentiality and clearly maintained responsibilities of the team. Knowledge that this disorder is often difficult to manage, the team remained committed to periodic check-ins to lessen the risk of symptoms again spiraling out of control and again creating severe stress for Nathan and his family.

Interventions Appropriate for the School Counselor

Developmental school counseling programs emphasize providing students with numerous opportunity to master requisite skills children and adolescents will need to be successful in school and in life endeavors (Gibson, Mitchell, & Basile, 1993; Muro & Dinkmeyer, 1977; Myrick, 1993). Developmental counseling approaches typically incorporate prevention, remediation, and crisis counseling goals (Myrick, 1993). In most counseling programs, these requisite skills are organized into a curriculum. Goals often include an understanding of the self and others, including the exploration of the student's attitudes and behaviors, and learning important skills for decision-

making, problem solving, communication, and enhancing interpersonal relationships (Gibson, Mitchell, & Basile, 1993; Muro & Dinkmeyer, 1997; Myrick, 1993; Snyder, 1993; see Parette & Holder-Brown, 1992). Thus, developmental school counseling may serve as a primary prevention and remedial intervention approach to children and adolescents manifesting psychosomatic symptomology.

After the collaborative assessment and intervention planning process, the role of the school counselor may be to foster problem solving techniques, coping skills, communication skills, and to use other interventions designed to reinforce age and culturally appropriate non-somatic expressions of emotional distress. Such specific intervention goals are often already part of developmental guidance curriculum, and are often the focuses of small-group counseling interventions implemented by school counselors. Additionally, in many schools, counselors offer services to parents, including supportive brief counseling and parent education classes (Myrick, 1993; Snyder, 1993). Any of these interventions, or a combination of some of them, may be adequate in alleviating somatic complaints in children and adolescents. For many children and adolescents, however, the counseling services provided in the school setting should be viewed as a complement to psychotherapeutic interventions provided by mental health providers working outside of the school. In the case where the child is not receiving counseling services from outside mental health providers, the school counselor may be called upon to provide more in-depth counseling interventions. The school counselor is best advised to accept this role only as appropriate to his or her level of training and experience, and in accord with the expectations specific to the school (Baker, 1992).

School counselors with a developmental approach to school counseling also provide consultation services to teachers (Gibson, Mitchell, & Basile, 1993; Harrison, 1993; Myrick, 1993). Regarding children with somatic symptoms, the school counselor may need to work with classroom teachers to help them understand the needs of children with somatoform disorders. Additionally, they may need to assist teachers in building a supportive classroom environment and emphasize the importance of teaching children problem solving and decision-making skills. Three specific classroom interventions are mentioned here.

1. Teachers can be instructed in empathic and appropriate ways to allow for a child who presents psychosomatic complaints to express his or her feelings. The child might be offered to keep a daily feelings journal in which the teacher

can respond at the end of the day. This approach engages the teacher but lessens the child's need to interrupt class time or seek the teacher's attention inappropriately.

2. "Feeling well" might become a class project (see Jonson Cox, 1994). If attention is focused on only a child with psychosomatic complaints, she or he is likely to feel blame and possibly shame for genuine physical feelings. The classroom project can encourage all students to emphasize feeling well, perhaps even when some children would find complaining easier.

3. Teachers might enter into a behavioral intervention that rewards class attendance and punctuality. Such an intervention needs to be carefully orchestrated lest the likely-absent child feels unfairly singled out. If the child can persevere with some physical discomfort to "make it through the day" the child can be rewarded in sight of his or her peers-a potent social motivator.

Work with parents is also well within the framework of developmental guidance (Gibson, Mitchell, & Basile, 1993; Myrick, 1993; Snyder, 1993), and school counselors may also need to provide parents with information about psychosomatic symptomology. Providing support would also be important for parents who may be struggling with the management of behaviors associated with the somatoform disorders and comorbid disorders. A parenting skills course may be beneficial to many of these parents. Instilling hope that proper intervention can help their child, for parents who have reached their "wits end" is a powerful intervention in itself. Depending on school counselors' particular role definition, the use of psychoeducational small groups might be an opportunity to disseminate needed information to parents and guardians. Simultaneously, such groups offer peer support and valuable networking among adults. School counselors are reminded that with complicated disorders it is rarely beneficial to "take on more than we can handle." This is rationale to invite other providers to be team players with a common purpose: The axiom of "many hands, makes lighter work" may apply.

The prognosis for Nathan's improvement, based on the effort by Ms. Rivera and the multidisciplinary team that ultimately engaged numerous community-based services including physician, clinical psychologist, and mental health counselor, is very optimistic. The nature of this particular somatoform disorder and the relatively complicated treatment plan that ensued is difficult and challenging. By utilizing all of her "counselor expertise" including counseling, coordination, and consultation (see Campbell & Dahir,

1997), Ms. Rivera contributes to Nathan's promising outlook. Nathan's case exemplifies the effectiveness of multidisciplinary "team" assessment and treatment efforts (see Mash & Terdal, 1997). What can appear intractable to any one individual often is manageable when approached collaboratively. Best of all, Nathan reports he is feeling somewhat better. He is performing well in school and although he becomes discouraged easily, he looks forward to continued improvement. He and his family are hopeful.

Summary

The school counselor can play an important role in the initial assessment of the school-aged child with chronic, recurrent physical symptoms. Given the prevalence of psychosomatic disorders at a rate estimated at 5-17% among children, it is likely that the school counselor will encounter these children, and awareness of common presentations of this group of disorders is important. Also important is knowledge of DSM-IV terminology used by collaborating medical and mental health providers, as well as knowledge of other disorders or psychosocial stressors that may cause psychosomatic symptoms. The school counselor is in a position of gathering useful information to be used in the medical and psychological evaluation of the child, and also may perform important work in prevention and intervention efforts, both with the student and his or her family.

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The Client Developed Daily Inventory: A Self-Directed Evaluation of Personal Performance and Experience

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College students present significant challenges in counseling when con-fronted about their propensity towards fatalism and self-pity when experiencing events perceived as "a bad day." Such pessimistic views of li fe are generally based on difficulties experienced by the student in just one area of his/her experience and can tax the patience of even the most seasoned of counselors. The Client Directed Daily Inventory (CDDI) is a tool that counselors can when counseling students to help them take a m ore generalized view of their life situations. The CDDI asks studen,along with their counselor, to choose a range of criteria that more adequately represent their daily experience, and to rate them on a Likert-type scale. Included are aspects not considered by the students to be their primary stressors. They are then asked to graph the results. This article outlines the clinical uses of the scale.

Introduction

Students in higher education seek counseling for varied and disparate reasons. From a desire to fine tune study skills and deal with problems related to procrastination and time management to serious personal problems requiring psychotherapy and medication, students find their way to the campus counseling center. These students are as likely to seek counseling via the informal recommendations of friends who have received treatment as they are to be referred by the faculty, other counselors, or parents. Such students may come voluntarily or, in some cases, be mandated by a third party. Regardless of the reasons surrounding the initial contact, each student brings a unique perspective on the nature and origin of his/her presenting problem(s).

The Greek philosopher Epictetus (cited in Ellis, 1979) wrote in the first century AD, "Men [sic] feel disturbed not by things, but by the view which they take of them" (p. 54). Shakespeare (Hibbard, 1987) echoes this sentiment in Hamlet (Act II, Scene II) when he wrote, "There [exists] nothing either good or bad but thinking makes it so." These are but two examples of our historic awareness of the role cognition plays in affecting our view of the world and the events we encounter. These admonitions of early philosophy and literature are employed by contemporary cognitive-behavior therapy, which has argued that clients have far greater potency in coping with their problems than they realize (Alford & Beck, 1997; Beck, Rush, Shaw, & Emery, 1979).

While cognitive-behavioral techniques do not represent a new approach to the delivery of care, new applications of this approach are being developed. Ollendick (1995) discusses the use of cognitive-behavioral treatment of panic disorder with agoraphobia in adolescents. Overholser (1995) addresses the use of this technique in the treatment of compulsive rituals. Turner (1987) used cognitive-behavioral techniques in the treatment of borderline personality disorders and Kadden (1995) reviewed cognitive-behavioral approaches to alcoholism treatment.

A common element in each of these examples is the use of a counseling strategy designed to alert clients to their propensity towards irrational thinking and to restructure cognitive distortions (Burns, 1989). To accomplish this, a number of techniques enable counselors to identify and then confront these distortions. An example of such a technique, simple in design and easy to employ, is the Client Directed Daily Inventory, or CDDI (Chapman, 1985). Intended for use between formal counseling sessions as homework in order to counter a client's fatalism, the CDDI provides a simple yet effective alternative to a negativistic and self-deprecating approach to evaluating daily events.

The CDDI directs the student to consider multiple issues when reviewing a day's events and personal experience during that day. This technique also serves to actively involve the student in the counseling process as he/she identifies specific issues of importance and the continuum from negative to positive for each. This technique of involving the student in the design of the inventory fosters accelerated change, including more active participation in counseling.

The Client Directed Daily Inventory

The Client Directed Daily Inventory (CDDI) is a simple tool designed to minimize a student's tendency to categorize an entire day as "bad" when experiencing relatively few negative events. (It should be noted that the inventory is not designed for use with students who have experienced significant trauma such as the loss of a loved one or physical violence). By customizing the inventory to reflect the unique personal perspectives of each client, the student is more likely to view the assignment as personally useful and counseling as a collaborative effort likely to result in improvement in the presented problem.

Prochaska, DiClemente, and Norcross (1992) outline five stages in the process of changing behavior: 1) precontemplation–no intention to change in the immediate future, 2) contemplation–awareness of a problem and consideration of change, but no commitment to do so, 3) preparation–both intent and recognized plan for change in the near future, 4) action–implementation of plan to change, and 5) maintenance–work to prevent relapse. The CDDI is particularly useful with those students who are in the "precontemplation stage." These students do not see their personal problems as related to their thinking and, consequently, see no reason to change their behavior. Often called "denial," this belief system is considered to be a hallmark of most client behavioral problems. For the student who is unable to see the connection between presenting problems, personal thinking, and undesirable consequences, emotional upset is often perceived as the result of external forces that have sought to victimize the student. The resulting fatalistic or cynical view of life often prompts a student to adopt a stance of self-pity. This egocentric behavior is often steeped in a long list of perceived negative experiences which become the student's justification for assuming a defeatist attitude, catastrophizing (Ellis & Harper, 1975) or simply giving up. Counselors working with such students in higher education often encounter the student's belief that dropping a course or withdrawing from school is the only possible solution to their dilemma.

By teaching students to evaluate their personal situation as an aggregate of experience in several important life-areas, rather than the result of a single experience or experiences in a single aspect of life, the counselor is able to challenge the student's fatalism. By helping the student appreciate the role personal views can play in the evaluation of any given incident, the counselor brings the student to a point where the many and varied events of

a given day must be considered in order to complete the assigned task. This strategy is designed to motivate students to look at the entirety of experience rather than simply focus on the negative events proffered as justification of a fatalistic perception of life. It increases the likelihood that the student will recognize the positive as well as negative aspects of life. The CDDI enables the student to better recognize the cause-and-effect relationship between personal behavior and experience, thereby facilitating movement through the successive stages in the model of change outlined above.

Denial is frequently presented as characteristic of a student's lack of interest in attempting change in his/her approach to collegiate life. Responding to that denial is considered a necessary skill of the effective counselor, especially when dealing with addictions (Lewis, Dana, & Blevins, 1994). Counselors who encounter denial and efficiently confront it will facilitate a student's movement through the first three of the five stages of change. The CDDI has been designed to assist the counselor who encounters that particular type of denial sometimes referred to as fatalism.

During a typical counseling session where this technique is employed, students are directed to:

1. Identify the key foci they use to evaluate a typical day. Most students with whom the author has employed this technique have identified between four and six foci, for example physical health, academic/job performance, a "personal relationship," peace of mind, and "social life" being some of the more frequently noted.

2. Establish a five point Likert-type rating scale for each focus with one pole (1) representing a worst case scenario and the opposite pole (5) a best case scenario. Students are then asked to specify these subjective determinations with specific examples, providing an example of a "1" and "5" for each of the categories noted by the student.

Students are instructed to use the resulting scale to evaluate their individual days between sessions. A numerical average of the scores for each focus enables the student to more accurately rate each day by quantifying events according to a rating scale of his/her own making. These daily averages are then plotted on a graph, the result of which becomes a visual representation of the student's week. In essence, the student not only quantifies the evaluation of each day, but tracks the result as well, producing a graphic representation of change.

While the above "instructions" could be printed and provided as a handout, discussing the various foci and their poles can provide valuable clinical insight. Likewise, the discussion also serves to more actively engage the student in the process of counseling. Further, this one-to-one introduction of the inventory enables the counselor to demonstrate its use by asking the student to practice, using the previous day's events and experience as data. By rating the previous day on each of the identified foci, all the time under the supervision of the counselor who can help the student explore each area to be evaluated, the student learns how to complete the assignment while at the same time experiencing a demonstration of its effectiveness. The counselor benefits by learning of the studentís core beliefs and typical ways of thinking, or schema (Alford & Beck, 1997; Persons, 1993).

It is recommended that the counselor ask the student to arbitrarily rate the previous day on a scale of one-to-five before going through the individual steps outlined above. Generally, the studentís perception of the day will result in a rating below the mean realized by averaging the actual scores assigned to each individual area. This demonstrates to the student the inaccuracies of a one-dimensional summarizing of one's day.

Because the CDDI is tailored to the individual perspectives of the student, it works as well with mandated referrals as with the student voluntarily seeking help because of poor academic performance. A case study follows to illustrate the use of the CDDI and individualized development of its scales.

Step I: Identify "Key Indicators" For Evaluating Performance.

Michael is a 20-year-old college junior who had been in counseling for approximately three months. His presenting problem concerned his poor academic performance and the fear that his grade point average would jeopardize his receiving post-graduation employment. We established that his "self-talk"or cognitive distortions (Burns, 1989) were at the heart of his difficulty. A particularly troublesome habit for Michael was his tendency to dwell on a single negative experience, poor grades for example, and project his resulting feelings of failure and worthlessness into the future, what Burns refers to as a "Fortuneteller Error" (p. 45). The resulting expectation that he would fail again, never graduate, and have thousands of dollars in loans to repay with no income, had the obvious result of increasing anxiety, producing a generalized sense of impotency regarding his academic performance. This gave rise to a perceived future conspicuously bereft of any possibility of success.

Michael was asked to select several factors that he believed determined the outcome of a particular day. These included (a) academic performance, (b) physical health, (c) social interactions/relationship, (d) current job, and (e) the performance of his car (he is a commuter with a late model auto).

Step II: Labeling Poles

Have the student establish the poles which define the continuum for each key indicator and label them as "1" for the worst case scenario (e.g., awful) through "5" for the best case scenario (e.g., rapture). The adjectives are arbitrary and it is recommended that you have the student identify those terms that signify a worst/best case scenario for him/her. It is important that the student quantify his/her passage through this continuum by identifying specific examples of events or occurrences that warrant a specific rating. For example, Michael identified an "awful" day academically as a day when he received a failing grade on a major project and/or would be called on in class when unprepared. A "rapturous" day academically would be to receive a "B" or better grade on a project, be prepared for class, and/or be able to respond to the professor's direct questions or participate in a class discussion. He provided similar criteria for each of the remaining four foci.

Step III: Rate the Previous Day.

Using the resulting personalized scale, ask the student to rate the previous day. This allows the student to practice the technique and serves as an example of how to score each indicator. When done, have the student sum the individual scores and determine a simple numerical average. This mean can now be said to represent a more accurate or objective appraisal of how "good" or "bad" a specific day has actually been.

Michael had been asked for his subjective impression of how "good" the previous day had been. He said, "it sucked" and cited a poor grade he had received on a paper as the justification for this assessment. When he rated each of his five foci as outlined above, summed the scores, and found the mean, the day he had said "sucked" had a mean score of 3.8. Smiling, he said, "I guess it wasn't really that bad."

Step IV: Repeat Step III Daily.

Have the student repeat Step III daily during the period between appointments. Have the student graph the results. Depending upon the experience of your student, you may need to provide instruction on how to prepare a graph. I generally offer the student a piece of graph paper on which the "X" (date) and "Y" (rating) axis have been labeled. Use a review of this chart as a way to start the next session. You may even choose to repeat this as a part of your counseling for several weeks.

As Michael employed the CDDI daily for three weeks, a pattern began to emerge. While there were "peaks and valleys" in the chart which he kept, with discussion it became clear that academic performance was the most frequent explanation for these changes. This information allowed us to focus on Michael's automatic thoughts related to both his academic prowess "before" he would attempt assignments and his interpretation of his result "after" the fact. Recognizing the role this self-talk would have on his ability to study, and consequently perform, as well as his sense of self-esteem when receiving feedback on his performance, resulted in an increase in Michael's self-efficacy.

Michael was able to successfully address his concerns about his academic performance. He stabilized his grades, was able to earn "B" and "C" grades in even his most difficult courses and graduated with a grade point average of 2.47. While clearly not a stellar performance, this represented a significant improvement over his academic performance before seeking counseling. In addition to the stabilization of grades and successful graduation as a Communication major, Michael established a monogamous relationship with a female classmate. At the time of his graduation, that relationship had been continuous for eighteen months.

Conclusion

While the CDDI is a simple, personalized tool counselors can employ to address a student's tendency to focus on one dimension of life, it is not designed as a substitute for assertively engaging personal trauma. For the individual who endures the shock of rape or the death of a loved one, other more traditional counseling interventions are recommended as the CDDI is intended for use with the student whose generalized negativity or fatalism casts a shadow over his/her collegiate performance. Additionally, while originally designed to be used with student populations, the CDDI is an instrument

suitable to use in counseling a variety of populations, including adults, couples and persons with addictions.

When used appropriately, the result of this inventory is two-fold. First, a graphic portrayal of the student's perception of his/her life will develop. This is something tangible to which the student can relate and discuss during counseling. Second, students will begin to view life as just a very large data set where even the serious outliers tend to be folded into the mean. Regardless of which result is most beneficial, the inventory enables the counselor to engage the student in a discussion of his/her ability to affect change in one's personal life.

Different theories of counseling yield various positions on the etiology of the problems students bring to counseling. Whether a counselor's resulting focus in therapy is the student's past experience or his/her cognitive distortions, the purpose of counseling is to engage the student in the recovery process and affect improvement in the presenting problem (ACA, 1999). The CDDI is an easy to use tool which has been designed to assist counselors of varying theoretical orientations to teach their students how to change their personal perceptions of the events and experiences they use to evaluate the quality of their life.

If one of the responsibilities counselors accept in the pursuit of this profession is to assist students in focusing on the personal goals they hope to achieve, then we are obligated to explore options that promote decision making, problem solving, and coping with change skills. The CDDI enables counselors to fulfill these obligations while at the same time teaching students a skill that will serve them indefinitely.

Figure 1

Assertiveness

0 1 2 3 4

"0" indicates total compliance without registering any sense of personal feelings, to respond totally to fear of being rejected/disliked, rationalizing or minimizing anger/resentment, to behave contrary to beliefs.	"4" indicates an assertive response in all situation of concern, to confront each area of anger/resentment prompting, to return for replacement of damaged goods, lodge complaints of faulty service.

Figure 2

Physical Well-being

0 1 2 3 4

"0" indicates illness, pain, uncomfortable to the point of being unproductive, sleeplessness.	"4" indicates an absence of illness, being rested, having slept well, free of aches and pains.

Figure 3

Family Contact/Involvement

0 1 2 3 4

"0" indicates an indulgence in anger, to ignore, demean, cut short, or dismiss family as bothersome or "in the way."	"4" indicates talking with significant others, listening and responding to significant attention, to laugh, joke, and otherwise be "with them".

Figure 4

Asking/Accepting

0 1 2 3 4

"0" indicates isolation, withdrawal, and avoidance of contact with oters/Higher Power.	"4" indicates the time spent reflecting in prayer or meditation to relate to personal sense of a "Higher Power," talking with a recognized helper.

Figure 5

Sense of Accomplishment

0 1 2 3 4

"0" indicates procrastination, indecision, indecisiveness, and avoidance of responsibilities.	"4" indicates having set and met realistic goals, addressed both large and small issues, decisive action devoid of procrastination.

Figure 6

Peace of Mind

0 1 2 3 4

"0" indicates anger, resentment, self-pity, doubt, fear.	"4" indicates a sense of harmony, being a part of the greater whole, being comfortable with ones position at the present.

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Sarah's Story: Using Ritual Therapy to Address Psychospiritual Issues in Treating Survivors of Childhood Sexual Abuse

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"Sarah's" story is a true account of one individual's healing from the trauma of childhood sexual abuse through counseling, spiritual growth, and the use of therapeutic ritual. The article explores the relationship between the psychospiritual issues associated with childhood sexual abuse and commonly designated treatment goals. Addressing psychospiritual issues is shown to be the key to achieving assimilation and healing. Ritual therapy is suggested as a method for helping clients accomplish this task through the discovery of metameaning. A description of Sarah's therapeuti c ritual is offered as a model for treatment design, and its efficacy in Sarah's case is evaluated.

At age 43, Sarah sought counseling to decrease her alcohol and drug use after her second significant long-term relationship ended suddenly and painfully. Feeling that she was connected to no one, Sarah began a journey into herself that involved uncovering layer after layer of pain. The choice to face the darkness and despair of her depression gave Sarah the resolution to end her substance abuse. Yet Sarah's storm inside continued to rage. In desperation, she agreed to medication, and some stability returned. However, the final layer was yet to be unearthed. When her therapist posed the fateful

question, "What is your earliest childhood memory?" Sarah was forced to look into the face of fear and name her demon. Sarah was a survivor of incest.

The Prevalence of Childhood Sexual Abuse

Although statistics regarding the incidence of sexual abuse vary, the magnitude of the problem is alarming. It is estimated that 20% to 45% of women and 10% to 18% of men in the United States and Canada have been sexually abused as children, and experts agree that these figures may be underestimates (Morrow & Smith, 1995). In a survey of 930 adult women in San Francisco, Russell (1986) found that 16% had been sexually abused by a relative before the age of 18, and 4.5% had been sexually abused by their fathers. This survey indicated that incestuous abuse before 18 and extrafamilial child sexual abuse before 14 had quadrupled between the early 1900s and 1973.

The effects of childhood sexual abuse are significant and long term, and may include chronic anxiety and depression; suicidal ideation (Briere, 1992; Herman, 1992); difficulties with trust and intimacy (Courtois, 1979); sexual dysfunction (Masters, Schwartz, & Galperin, 1993); somatic symptoms, including sleep disturbances, eating disorders, and gastrointestinal complaints (Herman, 1992); and self-medication with alcohol and drugs (Masters et al., 1993). People who have been sexually abused are also at greater risk of future victimization (Finkelhor et al., 1986; Russell, 1986) and are twice as likely to become victims of rape, sexual harassment, or battering (Herman, 1992).

The Need for a Psychospiritual Focus in Treating Childhood Sexual Abuse

A significant number of cases confronting counselors today involve childhood sexual abuse either as a presenting concern or as an issue that emerges during the course of therapy. The frequency and intractability of such cases underscores the need for mental health professionals to be skilled in a variety of treatment modalities to deal with the root trauma and its residual effects. This need for innovative treatment strategies has been clearly articulated in recent literature (Elmore, Lingg, & Schwartz, 1996; Winder, 1996). Psychoanalysis, cognitive and behavioral techniques, transactional analysis, relationship therapies, gestalt, and hypnosis are all currently being used by therapists with varying degrees of success (Elmore et al., 1996). In addition, because posttraumatic symptomatology is so common in sexual abuse cases (Herman, 1992; Horowitz, 1986; Masters et al., 1993) proposed a trauma-based treatment model.

Unfortunately, no commonly used form of short-term therapy is generally successful for victims of childhood sexual abuse. According to Lemoncelli and Carey (1996), this failure is the result of an inadequate focus on the psychospiritual dimensions of the pathology. Childhood sexual abuse strikes at the very heart of the cognitive developmental processes necessary for individuals to experience a sense of essential wellness. Because the victim is physically traumatized, his or her basic sense of safety in the universe is shattered and the capacity for meaningful faith is undermined. This betrayal has a devastating effect on the capacity of the abuse victim to believe in, and thus to create, a coherent, positive image of the world or the self. Even apart from the more dramatic dissociative pathologies of splitting and multiple personality disorder, the victim often experiences himself or herself more as "object" than as "person" and is susceptible to derealization, depersonalization, and psychic numbing (Classen, Koopman, & Spiegel, 1993). Relationships are pervaded by pessimism, anxiety, mistrust, and a restricted range of feeling. Many physiological alterations typical of posttraumatic stress disorder (PTSD) are also associated with childhood sexual trauma, particularly if the perpetrator was the child's father rather than a stranger (Meichenbaum, 1996).

Ganje-Fling and McCarthy (1991) reported that both the psychological and spiritual development of abuse victims are arrested at the age level at which the abuse occurs. Janoff-Bulman (1992) reported that the effects that trauma can have on the belief system of victims include a debilitating sense of vulnerability; loss of belief that life events will occur in an orderly, predictable, or fair manner; loss of belief that life is meaningful; loss of the ability to feel a sense of self-worth; inability to trust others, or to trust the life process; feeling that others are not worth relating to; and loss of belief in justice or innocence. This conflicted view of reality represents a holistic pathogenic mistrust that is precisely the inverse of healthy spirituality or of functional faith, defined as a sense of being "at home" in the universe; a capacity for unconditional trust (Buber, 1970); a comprehensive will-to-meaning (Tillich, 1955); or a receptivity to belief in intrinsic values such as beauty, goodness, or truth (Maslow, 1964). Without this capacity, the victim is ill-equipped to carry out the fundamental existential task of achieving selfhood. His or her very survival may even be in question. This is why Frankl (1984) referred to the loss of the capacity for faith–in the sense of an inability to discover holistic personal meaning–as equivalent to the loss of the future itself.

How can a wounded individual "reacquire" his or her future? According to Frankl (1984), one can recover and discover meaning in life in three ways: (a) by creating a work or doing a deed, (b) by experiencing something or encountering someone, and (c) by the attitude one takes toward unavoidable suffering. It is the third task that most concerns us here. During his confinement in Auschwitz, Frankl observed that those who could frame their suffering in the context of some goal or meaning tended to survive. As Nietzsche put it, "He who has a why to live can bear with almost any how" (as cited in Frankl, 1984, p. 97). Suffering is qualitatively transformed when it is suffused with meaning. It ceases to be mere suffering when it is subsumed within a larger teleological context. It may then become an element in the process of catharsis and healing. Confidence in meaning within such a larger teleological context–here defined as metameaning–is the essence of faith, of a working spirituality, and of the will to live in the face of catastrophic trauma. For this reason, the overcoming of psychospiritual dysfunction via the acquisition of metameaning is essential to the successful treatment of victims of childhood sexual abuse.

Defining Treatment Goals

According to Sarah's mother, Sarah was first molested at the age of 2 by a male cousin who was babysitting her. Sarah only remembers lying in her crib feeling very afraid and alone. Several years later, her older half-brother began sexually abusing Sarah in front of her younger brother. Sarah's older brother also assaulted her physically, punching her in the stomach and stealing and destroying her property. She would later write: "I think he stole my tears, my ability to weep." She eventually told her mother about the sexual abuse. Her mother responded that such behavior was wrong and that she would take care of it. Sarah's mother told her father about the incidents, but he has no recollection of the conversation today. The pattern of abuse did not change, although Sarah remembers her father once beating her brother with a belt, after which the brother showed her his welts and said "Look what you caused." Sarah entered adulthood with deep feelings of shame and of being unlovable.

The treatment issues with which survivors of child abuse have to deal have been delineated variously by therapists. Lebowitz, Harvey, and Herman (1993) described seven domains involved in recovery: (1) filling in memory gaps, creating a meaningful life narrative; (2) equalizing and integrating the range of emotions experienced; (3) linking memory and affect, remembering the past clearly yet reacting in the "here and now"; (4) gaining control over

PTSD symptoms; (5) replacing self-destructive attitudes and behavior with a realistic sense of self and of just blame toward others; (6) developing an ability to feel connected to others and to negotiate relationships; and (7) getting a sense of the realistic meaning of the trauma; incorporating ambiguity and contradiction; feeling hopeful about the self, the world, and the future. Ratican (1992) suggested the following goals for therapy: (a) establishing a safe environment, (b) focusing on strengths to overcome helplessness and low self-esteem, (c) regaining a sense of power and control, (d) shifting the responsibility from self to perpetrator, (e) exploring the family dynamics that allowed the abuse to occur, (f) learning to trust and to set appropriate boundaries, (g) grieving for what is lost, and (h) integrating the trauma of the past with the experience of the self in the present. Herman (1992) portrayed the three main major therapeutic stages as: (a) establishing safety, (b) reconstructing the trauma story, and (c) restoring the connection between the survivor and the community.

These treatment goal models obviously overlap in many areas. Our special sphere of interest has to do with the final, cumulative, or most holistic phase of healing. The authors of the treatment goal schemas previously stated described the highest stages of healing in terms of effectual hope (Harvey, as cited in Lebowitz et al., 1993), full integration (Ratican, 1992), and restored community (Herman, as cited in Lebowitz et al., 1993). These descriptors are markedly similar to signifiers of spiritual wellness that have appeared in recent counseling literature (Ganje-Fling & McCarthy, 1996). For example, Worthington (1989) identified four themes or functions inherent in spirituality, three of which explicitly parallel the treatment goals we have enumerated. First, spirituality is concerned with providing hope, particularly in the face of uncertainty and suffering. Second, spirituality focuses on finding an integrated sense of purpose or personal affirmation in which an authentic experience of self-worth can be rooted. Third, spirituality seeks community and communion with others as a way of expressing meaning, harmony, and purpose.

The Why Question: Key to Assimilation and Healing

As relevant as these three goals are for both therapeutic and spiritual wellness, Worthington's (1989) fourth function of spirituality–the attempt to relate oneself to the Mysterious, the Unknown, the *why* that gives meaning to existence–may be the overlooked psychospiritual key to achieving maximal healing for victims of abuse. Herman (1992) observed that, in the course of therapy, all penultimate questions are finally reduced to one ultimate question:

Why? Unless an answer to this question is discovered, recovery and healing will be incomplete. Meichenbaum (1994) underscored the trauma victim's need to therapeutically address psychospiritual issues when he noted that PTSD patients often get stuck in trying to answer the why question: Why did this happen to me? What does it mean? Whom can I trust? To use Frankl's (1984) terminology, the victim must not only deal with trauma-based anxiety as a result of the sexual abuse, but also with specific noogenic (meaning-related) anxiety that arises from related existential *why* questions.

In this regard, it is vital to note that the primary therapeutic need for those suffering childhood sexual abuse is not catharsis, but assimilation (Herman & Schatzow, 1987). Bringing the details of the abuse back into memory is recognized as an important and necessary step in most childhood sexual abuse counseling treatment models. However, to simply reconnect with the pain of abuse without integrating the trauma is likely to result in greater dissociation, and a worsening of symptoms such as anxiety, depression, and confusion (Olio & Cornell, 1993). Ultimately, the therapist must help the survivor not only to remember the abuse, but also to fully accept the reality of the abuse and somehow make sense of it within the larger context of his or her life.

This task underscores once again the inescapable overlap between the therapeutic and spiritual developmental domains. Harris (1990) defined spiritual questions as those dealing with who we are, why we are here, and what is required of us. Pate and Bondi (1992) conceived of spirituality as having to do with issues defining our place in the universe. Chandler, Miner-Holden, and Kolander (1992) viewed spirituality as concerned with that which we hold as sacred, that which constitutes our ultimate context for understanding things. If the why question is to be answered, the discovery of spiritual meaning, or metameaning, is the foundational psychospiritual task on which the therapeutic work of assimilation must be grounded.

Noogenic Therapeutic Tasks

Answering the question *why* involves great courage and real risk. *Emotionally*, answering this question involves opening to the full depth of the pain caused by the abuse. Survivors are understandably reluctant to encounter such overwhelming, seemingly bottomless suffering. They may also refuse to mourn as a way of denying victory to the abuser. However, survivors cannot engage the *why* question in its true profundity unless they are willing to plumb

the depths of their own pain. "Only through mourning everything that she has lost can the patient discover her indestructible inner life" (Herman, 1992, p. 188).

Confronting the *why* question is also a *cognitive* task. It involves reconstructing the past, retelling one's story, and understanding the dynamics that allowed the abuse to occur. On a higher cognitive level, answering the why question will involve facing and exploring the broader implications of what has occurred. To fully engage this question, it is necessary for the client to squarely face the full intensity of his or her anger at God or at whatever constitutes the client's "ultimate environment" (Fowler, 1981, p. 146). This may necessitate a painful restructuring or abandonment of old ways of believing and thinking, and the creation or discovery of new myths or of a new, more developmentally mature, faith (Fowler, 1981). This is difficult, but essential, therapeutic work. Frankl (1984) noted that, "*logos* [transforming meaning] is deeper than logic" (p. 141). For healing to take place, a deep reconciling insight must occur not only rationally, but also transrationally.

Finally, answering this why question involves acts of will. Specifically, it frequently requires that the client reengage important persons in his or her life to address the truth of what has occurred. The client must find the courage and willingness to live out the answers to his or her questions by reconnecting with life, with other individuals, and with the community.

Ritual Therapy and the Recovery of Metameaning

If addressing the psychospiritual issues surrounding the question of suffering is an essential therapeutic task for the victim of childhood sexual abuse, then mental health practitioners need answers for critical questions such as "How can we help clients derive meaning as they reflect on such incomprehensible atrocities?" "How can we help them develop new schemas of power and hope when faced with their own powerlessness and despair?" "How do we discover and communicate metameaning at all?"

One increasingly popular technique currently being used to explore the fruitful intersection of spirituality and therapy is ritual therapy. In rediscovering the therapeutic potential of ritual and myth, therapists and theorists like Hillman (1994) and Moore (1994) are only reaffirming techniques and perspectives that have functioned psychotherapeutically in countless cultures throughout history. Freud (as cited in Corey, 1996) proposed that

symbolic perception, such as that evinced in dreams, was a "royal road to the unconscious" (p. 118), and thus a path to liberating insight may have been novel to his contemporaries. However, such a concept would be functionally self-evident for Native Americans, Australian aborigines, the Naskapi of Labrador, and myriad other cultures that regard symbolic dreams and visions as revelatory, and which preserved and communicated metameaning through core symbolic rituals. To cite one example: The ancient Babylonians, Egyptians, and Greeks practiced incubation as a means of therapy. This process involved going to special temples set apart as "dream-hospitals," making a request for help to the divine powers, and sleeping in the temple precinct in order to receive a visitation from the god and an answer to the request in a dream. Many inscriptions by grateful practitioners of incubation in Greece have survived that testify to the healing of sterility, physical disease, and a host of other complaints (Lang & Taylor, 1980).

It is through ritual that we "do" myth, allowing the power of mythic symbolism to penetrate beyond our surface analytical cognition and transformatively affect our deeper intuitive and emotional selves (Parker & Horton, 1995). Why ritual should function as such an effective instrument in these areas is an evocative and intriguing question. Scholars of myth speak of the power of ritual to create liminality, which is defined as "the domain of... uncommon sense" representing "a limitless freedom, a symbolic freedom of action which is denied to the norm-bound incumbent of a status in a social structure .... Liminality is pure potency, where anything can happen" (Turner, as cited in Doty, 1986, p. 92). Intuitively valid ritual thus not only provides an opening for change, it also performs an orectic function; that is, it stimulates the appetite or desire for change (Turner, as cited in Doty, 1986, p. 90). Such motivation is an invaluable element in achieving recovery. It sets the stage for the survivor of abuse to address the why question and other psychospiritual issues emotionally, cognitively, volitionally, and ultimately transrationally at the level of metameaning.

Sarah's Ritual: A Time to Heal

In the remainder of this article, we examine the genesis, structure, and effects of the ritual that Sarah, her therapist, and her minister orchestrated to aid in her healing. Sarah's ritual is exemplary in that she received excellent guidance and support throughout. Just as important, she was psychologically ready for an assimilative experience as a result of her therapy, her recovery process, and her determination to address her perceived psycho-spiritual

deficits. We believe that it was the confluence of these factors that proved decisive in allowing her to overcome the crippling power of abuse.

When at midlife, Sarah decided to stop masking her pain with substance abuse and to begin therapy, she also came to the conclusion that she had been wandering in a "spiritual wasteland" most of her adult life. In conjunction with her therapy, she began reading books on spirituality and psychology. One of these led her to the practice of *vipassana* meditation. This fundamental Buddhist discipline aims at cultivating mindful awareness, a sense of clear presence, and of being "awake." The meditator concentrates on the breath, while allowing the thoughts and sensations that arise from the mind and body to appear and pass away with equanimity and dispassion. Sarah's journal reveals that she gradually developed a deep appreciation for the subtle, yet powerfully transforming influence of this discipline.

> *Vipassana* has become a daily spiritual practice for me. Concentrating on my breath, I attempt to quiet the chatter of my mind. In the stillness of mind and body I await insight into myself and all things. I become more aware by observing the thoughts that come to my mind and then letting them go. It is not clear to me how, and in what ways, meditation works. I just know that when I meditate regularly I find that I am more at ease with myself and the world. For the first time in my life, I actually experience a feeling of connectedness and peacefulness. I still struggle with depression, emotional pain, and isolation, but meditation is one tool that seems to help me find my way through.

The therapeutic power of Sarah's newly awakened spirituality is evident in that it not only forced her to confront her addiction, but also gave her the power to overcome it. In her own words: "It became inescapably clear to me that the spiritual path I wished to follow was in direct opposition to my substance abuse."

A second, important psychospiritual watershed for Sarah was the discovery of a spiritual community. Achieving a sense of community was an important psychospiritual issue for Sarah because she believed that the Catholic Church in which she was raised relegated her to its perimeter because of her gender and her lesbian sexual orientation. After making the decision to seek spiritual community outside of the religion of her childhood, Sarah encountered the Unitarian-Universalist church, a nondogmatic religious

organization where the fact that she was a woman and a lesbian did not mark her out. In fact, her minister was a woman who was candid about her own committed same-sex relationship. Sarah also joined Magun, a women's drumming circle. This served to further enhance her self-esteem, and she found the practice of drumming was an effective noncognitive technique for centering and connecting with a sense of strength and vitality that was simultaneously physical, emotional, and spiritual.

Sarah's decision to explore the healing dimensions of ritual was born within the context of therapy. Her therapist suggested that Sarah design a personalized grieving ritual for herself. Intrigued by her own initial resistance to this idea, Sarah decided to undertake the project. She asked the minister at her church to help with the planning. Together they identified the central issues Sarah wanted her ritual to address and planned a ritual that would facilitate these changes. Sarah believes that once the process of ritual design was set in motion, it took on a powerful life of its own. The symbols and symmetry of the ritual evolved organically, and Sarah felt a strong sense of intuitive guidance. In retrospect, she thinks that much of the healing connected with the ritual occurred during the process of the planning itself.

Invitations to Sarah's ritual were mailed to her closest friends one month in advance. Guests were asked to bring a candle and any message they might want to share. Sarah designed an altar to hold the symbols that represented the transformational powers active in her life. These symbols included the aforementioned candles, which represented the energy of life, the "fire inside"; a chalice medallion, symbolic of Unitarianism, expressing Sarah's freedom to choose her spiritual path; a drum, representing the healing power Sarah had experienced through her drumming circle; her journal, representing her determination to be healed; a copy of *The Courage to Heal*, symbolizing writing as a vehicle for healing; a walking stick, signifying the healing power of "nature, movement, and Mother Earth"; a crystal ball, representing Sarah's connection to her therapist; a book of poetry Sarah wrote during the recovery process, signifying the creative force that was stifled by the abuse but was now returning; and a Buddhist meditation cushion, representing the clarifying awareness that arose as a result of Sarah's practice of mindfulness meditation. As Sarah explained it, this cushion was a symbol of her connection to "all that is." Sarah included on the altar a photograph of herself at age two, which served as a reminder that she was not responsible for the abuse and could let go of the shame associated with it. In addition to these symbols, Sarah wrote letters to her older brother and cousin confronting them with their culpability in the abuse. These were placed on the altar and mailed the next day.

Part I of Sarah's Ritual: Grieving

Sarah's minister opened the ceremony by telling a story about the relationship of suffering to beauty, using an analogy from Kahlil Gibran of an oyster that brought forth a pearl "of exceeding beauty" from its pain. Preparation of the altar followed as the chosen objects were placed on the altar and their symbolism explained. Friends read two of Sarah's poems dealing with the effects that the abuse had on her. After these readings, Sarah's drumming circle played a "centering piece" and the minister led the group in a guided meditation in which she spoke of the wisdom and strength that Sarah had within herself and of the love and support that surrounded Sarah in her circle of friends.

In the meditation, Sarah's minister spoke of the body as the place where memories are held, and said that as those memories were revisited during the course of the ritual, the help that should have been there for Sarah when she was a child would now be present. In this way, Sarah's minister set the stage for the practice of healing touch that would occur later.

Telling Her Story

Accompanied by a solitary drummer, whose playing symbolized "the heartbeat that never ended," Sarah then shared the history of her abuse with those attending the ritual as a way of overcoming her isolation, pain, and fear. She wrote in her journal:

> First and foremost, I want to tell my story completely. Why is this so important? In the hearing, others will come to know the vulnerable part of me, the part that I have kept locked away, isolating myself from others and from myself. By telling my story, I can relive it, yet change the ending. Instead of having to repress my feelings, I'll find release in their expression, comfort in finally being heard and acknowledged, and ultimately . . . connection.

Sarah read these words as a preface to relating the incidents of her childhood:

> What I want to do tonight is to tell my story, like I did when I was a child. But unlike when I was a child, today I want to be heard. This time I want to be believed. I want to let go of the pain that I have held inside for so many years. I need you to be brave enough to be a witness to my pain. And I want you to act. I need you to comfort me.

To avoid rambling or misspeaking herself through an excess of emotion, Sarah wrote her story out in script form. As she paused from time to time, she glanced up and saw that "those who encircled me were holding me, loving me." Tears–which she rarely allowed herself to have and never allowed others to see–ran uninhibitedly down her face. Of this moment, she wrote, "At last, my words are heard and reflected back to me. Written on the faces of my friends is my pain and sadness, and I know that I am not alone." As the first part of the ritual came to a close, her drumming circle sang a ritual song especially for Sarah: "How could anyone ever tell you/You are anything less than beautiful/How can anyone ever tell you/You are anything less than whole/How could anyone fail to notice/That your loving is a miracle/How deeply you're connected to my soul."

Part 2 of Sarah's Ritual: Healing

At the conclusion of Sarah's story, the portion of the ritual dedicated to healing began. Sarah and her minister deliberately incorporated healing touch, or "laying on of hands" (see Acts 8:17 for an example) as the centerpiece of this part of the ritual. Touch is among the most paradigmatic of ritual actions, representing an expression of the essential human need to achieve "non-distance" (Gurevitch, 1990, p. 192). The negative sexual abuse Sarah suffered as a child found an obvious positive counterpart in her reception of physical comfort from persons genuinely concerned for her welfare.

In Sarah's case, and perhaps in the case of sexual abuse victims in general, there are additional reasons that touch can serve as a powerful key to healing. Sarah learned early to "shut down" emotionally as a way to protect herself from feeling the pain of her abuse and as a corollary to her parents' denial. As a result, she became trapped in a dilemma. Her fear of being vulnerable kept others from witnessing her pain, but also restricted her from creatively encountering it herself. As Sarah's therapy progressed, she came to realize that only the choice to become vulnerable and risk intimacy would empower her to face and release her pain. The ritual was the vehicle through which she took this critical step. After the ritual, she wrote in her journal:

> Allowing all those who had come to aid in my healing to touch me precipitated a breakthrough for me on some deep level. I came full circle, from the 11-year-old girl who reached out to her mother and had her needs unmet, to the 45-year-old woman who finally trusted enough to ask that another hold her pain. I needed to be comforted, to be touched, to be held. Admitting and allowing this proved to be my most courageous act.

Sarah's minister introduced the healing touch portion of the ritual by sharing her thoughts on the power within the hands, and "how they tell stories and communicate in a language deeper than words." She invited the guests to look at their own hands and to "speak to" the healing and power within them. Guests then approached Sarah, singly and in small groups. Sarah describes what ensued:

> I took a seat in the middle of the circle, awaiting the "healing touch." The first pair of hands were placed upon my shoulder from behind. It was a firm touch, and I could feel the strength passing from them into my body. My therapist whispered, "You are a courageous woman." Someone reached out and held my face in the palm of their hands. I turned into it, much like an infant does when it recognizes its mother's touch. There was a litany of affirmations, as those who encircled me and laid their hands upon me, told me what I needed to hear as a child. When I realized that my own hands were tightly clenched inside my lap, I reached out, and others took my hands into theirs. I wept and allowed those around me to comfort me. I am most unclear about how we moved from this to what followed next. There was an interchange of words between myself and my guests. I spoke to each of the guests in turn, and communicated to them my gratitude for their special part in my healing. Again, I remember not so much the words themselves, but the feeling of the moment. I remember the laughter most. Laughter has such healing powers, and I have used it as a means of survival.

After returning to the outer part of the circle, Sarah's guests placed their candles on the altar and lit them. She, in turn, gave a gift to each person: bookmarks bearing a photograph taken by her of a sunrise on which she had written: "In healing we come to realize the only thing that has changed is our perception." The ritual was closed by powerful, upbeat drumming. Sarah retrieved her drum from its place by the altar and joyously joined in.

Sarah's Ritual: An Evaluation

Sarah's ritual both consolidated the clinical gains she achieved in the course of her therapy and effected a qualitative transformation in her self-concept. Her commentary shows that a large number of the treatment issues delineated by Lebowitz et al. (1993), Ratican (1992), and Herman (1992) were addressed in the context of the ritual. Some of the therapeutic goals most

effectively realized were reconstructing or telling the trauma story; grieving for what was lost; feeling hopeful about the self, the world, and the future; focusing on strengths to overcome helplessness and low self-esteem; regaining a sense of power and control; learning to trust; establishing safety; and developing an ability to feel connected to others. There is strong indication that Sarah made effective headway in achieving the stages of effectual hope (Lebowitz et al., 1993), full integration (Ratican, 1992), and restored community (Herman, 1992). Sarah's ritual helped her to accomplish the noogenic developmental tasks necessary for healing. Emotionally and existentially, her decision to risk intimacy by sharing her story with her spiritual community freed her to become vulnerable, to forsake her inner emotional frigidity and denial, and to achieve a decisive breakthrough in opening to and assimilating her pain. Cognitively, her ritual allowed her to reconstellate the symbols of the sacred that were personally significant for her, creating, in effect, a new mythos or transrational cognitive platform from which to establish a sense of metameaning and address the critical why question.

It is important to emphasize that before Sarah could reconstellate her symbols of the sacred in the context of ritual, she had to rediscover and connect with the sacred in her immediate experience. For this to occur, she had to perform critical tasks such as choosing recovery from her substance abuse, learning the discipline of meditation, and developing inner spiritual preparedness through deep mourning. Without this work, her ritual would not have had the effect that it did. Although many recent books by therapists testify to the power that is unleashed when clients use the "symbolic intercom" of ritual to effect catharsis in their lives (Munn as cited in Doty, 1986, p. 72), it should be stressed that the metamorphosis facilitated by ritual is neither effortless nor simply miraculous. Ritual is not a substitute for traditional therapy. Similarly, ritual cannot take the place of dealing honestly with psychospiritual developmental tasks. Ultimately, neither therapy nor ritual can fully bear fruit apart from determined attention to achieve essential wellness by genuinely addressing core psychospiritual issues.

Sarah's experience confirms Meichenbaum's (1994) contention that the why question is the key psychospiritual issue to be negotiated for victims of sexual abuse. Perhaps the most difficult task that victims have in this regard is to become free from deep-seated shame by forgiving themselves. This task is complicated by the profound interconnection that exists between the willingness and ability of suffering individuals to forgive themselves and their willingness and ability to "forgive God" (Casarjian, 1992).

Although Sarah expressed no theories about forgiveness in recounting her story, she clearly had become capable of self-forgiveness. She was also free from any need for retribution toward those who betrayed her. We hear evidence of Sarah's deep openness in her declaration that her meditation cushion was symbolic of her connection to "all that is." By implication, Sarah's connection to "all that is" was also a connection to the reality of her abuse, to her shame, and even to her abusers. But it was a connection mediated by the sacred; one in which the trauma and threatening ambiguity connected with her abuse are mitigated and assimilated in the overplus of meaning that qualifies the sacred. In the depth of this encounter, Sarah found a tramrational answer to the question why. Her work of assimilation was accomplished, and her shame was transformed into self-acceptance.

The symbols that emerge from the mythic imagination and become active in ritual have the power to constellate meaning, thus aligning the life of the individual with the depth and power of the sacred (Marie-Louise von Franz, as cited in Doty, 1986, pp. 151-152). This allows the wounded personality to draw healing power into his or her life situation and be restored by reconnecting with Herman's (1992) "indestructible inner life" (p. 188). Like dreams, "true" ritual partakes of the intuitive power and insight of the mythic imagination and thus has potentially profound therapeutic power. If we think of therapy as a kind of alchemy, then ritual may be regarded as a crucible in which the symbols of the sacred are placed, and through which their power is refined, distilled, and communicated to the wounded psyche of the victim of abuse.

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Experiential Pre-practicum Counselor Training

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This study contains a review of pre-practicum experiential training methods and presents the results of a survey that identifies when and how counselor education programs provide this form of training.

Effective counselor training calls for an approach that balances theoretical, clinical and practical/experiential training. This study focuses on one critical element: the practice component, where novice counselors learn to conceptualize client problems, formulate counseling goals, reflect client feelings (Claiborn & Dixon, 1982; Fuqua & Gade, 1982), develop relationship-building skills, and enhance interviewing skills (Hiebert & Johnson, 1994). Virtually all counselor education programs offer experiential training with clients in internship and practicum courses (McNeill & Ingram, 1983), but experiential training can also occur during earlier courses (e.g., Pre-practicum, Counseling Techniques, or Counseling Practice courses) (Lane, 1988; Sommers-Flanagan & Means, 1987).

Early, pre-practicum experiences are the particular focus of this study. Even though graduate students often work with pseudo-clients rather than real clients at this stage of their training, these experiences still offer important advantages. They help beginning counselors refine various counseling skills such as immediacy and focus on affect (Tracey, Hays, Malone & Herman, 1988, p.119.), increase relationship building, help students to cultivate comfort with being in the counselor's role, and aid in the professional growth of trainees (Cummings, 1992; Peterson & Nisenholz, 1995).

While counselor educators recognize the need for early experiential training, they face the dilemma of deciding when students will benefit most from these experiences and who will serve as practice-clients. While experiential activities are effective at any point in the student's training, working with actual clients is probably more appropriate at the end of the student's curriculum rather than at the beginning. Course work in theory, practice, diagnosis, and ethics prepares students to meet the challenge of offering counseling services to clients. By the end of their training, most students are ready to work with clients in practicum and internship settings but earlier in the program they are more appropriately assigned client analogs. Ethical concerns, finances, and practical issues greet counselor educators as they search for ways to provide experiential training for counseling students at various points in their training (Levitov, Fall & Jennings, 1999).

This study explores this problem by identifying methods that are currently used to provide pre-practicum counseling experiences for students. All students who progress through a counselor education curriculum encounter actual clients at the internship phase of training. The issue is therefore not whether a counselor education program offers experiential activities to its students or not, because every program offers these experiences; it is how these opportunities occur across the curriculum.

Review of Literature on Training

Methods of experiential training have been studied to a limited extent. A review of the existing literature reveals little consensus among counselor educators regarding which methods are most successful in training beginning counselors. While the question of relative effectiveness persists, there is little agreement about which methods are most widely used. Studies (Bailey, Deardorff & Nay, 1977; Parker, 1991) suggest that modeling and role-play practice form the main experiential training modalities in counselor education programs. The use of actors serving as clients and counselor training using computer simulations were identified as additional viable methods (Beamish & Dalen, 1990; Lane, 1988; Levitov, Fall & Jennings, 1999; Phillips, 1983).

Modeling, or a demonstration of counseling skills by professors and other exemplars, remains an attractive component in many counselor training programs. Eisenberg and Delaney (1970) established that modeling through

emulating a mentor offers one way that trainees may learn to behave as counselors. Peters, Cormier, and Cormier (1978) found that modeling, where written and videotaped models are used, was both an effective and efficient method for "strategy acquisition, short-term skill retention, and application of skills from a modeled to a non-modeled task on written and role-play measures" (p. 237). Aside from being effective, written and videotaped models are also cost effective because once they are recorded they can be used repeatedly (Newman & Fuqua, 1988).

Newman and Fuqua (1988) concluded that "negative modeling and positive modeling achieve similar training outcomes, at least in early counselor training" (p.126). This is a particularly interesting finding since negative modeling refers to demonstrated behaviors that are believed to reduce counseling effectiveness and positive modeling refers to demonstrated skills associated with a high level of counseling effectiveness. However, the learning processes that cause trainees to replicate the behaviors displayed in positive modeling seem to be different from those that cause trainees to avoid the behaviors displayed in negative modeling. Unfortunately, the differences in learning are not well understood. Some types of models are more successful than others. Role-play, for example, paired with a written model significantly enhanced the reflection of feeling responses of the students, while role-play paired with a video model did not (Froehle, Robinson & Kurpius, 1983). Role-play activities are typically used very early in counselor training (Gabriel, 1982). Thus technique helps trainees explore and understand their roles as counselors and the roles of others; and it offers an opportunity to obtain immediate feedback while practicing counseling skills (Ostand & Creaser, 1978). Also, the precision of the reflection-of-feeling responses steadily increases as a student either observes or participates in a greater number of role-playing practice sessions (Robinson & Cabianca, 1985). Role-play can also be used with other experiential activities. For example, role-play linked with modeling activities where students serve as clients for one another, can be a very efficacious training method (Cormier & Cormier, 1994; Ivey, 1994; Kasdorf & Gustafson, 1978). And Froehle et al. (1983) explained the benefits of role-play practice when combined with a written model. According to Robinson and Cabianca (1985), role-play activities work because observers learn what is modeled. Social-learning theory and theories about vicarious learning offer useful explanations of why modeling is effective. Because role-play relies upon different sources of learning, it can be usefully combined with various training alternatives or used singularly; it is a method that changes student behaviors

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While role-play activities seem to be the method of choice for pre-practicum experiential training, they also present problems. While role-play with other students in a particular program has the added advantage of allowing students to explore personal issues that might influence their ability to serve as a counselor (Egan, 1985), there are caveats. For example, in programs where classmates counsel fellow students in role-play situations, confidentiality concerns rapidly surface. Students are expected to maintain confidentiality within dual relationships with other students. Confidentiality issues are particularly complicated because students share many roles with one another at a time when they are just beginning to learn how to maintain confidences. Students can also be exposed to their classmates' problems and issues that could easily eclipse their level of skill and experience. Fly, van Bark, Weinman, Kitchner and Lang's (1997) findings suggest that graduate students often commit ethical violations with respect to confidentiality and professional boundaries. Both of these ethical concerns confront students when they role-play clients with their classmates.

Ethical concerns are not the only caveats to be found in role-play situations. For example, Lane (1988) suggested that when both participants in the role-play are aware of the purposes and techniques of the interview the student-client may unknowingly help the interviewer. Students serving as clients for one another can actually decrease the effectiveness and usefulness of the role-play experience.

Fortunately there are serviceable alternatives to role-play activities where students role-play clients for other students. At least two additional methods of obtaining analog clients exist. Phillips (1983) contended that a computer programmed to respond like a client would allow students to experiment with newly acquired skills in a safe and effective way. It also offers advantages when counselor educators assess counseling skill acquisition; the computer standardizes the process since each student interacts with the same "client." Computer simulation offers several advantages though "it is unlikely to provide trainees with opportunities to cope with the often capricious or intuitive behavior of clients" (Phillips, 1983, pp.26-27). Fuqua and Gade (1982) assert that practice should enhance the trainees ability to discriminate among cues that suggest the appropriateness of a given response and therefore concluded that a "live" client is necessary for this to occur. Computer programs might offer a useful middle-step between observing models and working with clients or client analogs.

The need for in vivo experiences that do not risk confidentiality and boundary issues are probably best met by role-playing activities where students within the counselor training program are not used. Sommers-Flanagan and Means (1987), for example, obtained volunteers to serve as clients for first-year graduate students from an introductory psychology research pool. The students are instructed to speak openly, preferably about issues of personal concern as they served as clients. This alternative resolves some confidentiality concerns since the graduate students did not have other relationships with the undergraduate clients, but it raised concerns about the ethical implications that arise when students serving as clients are expected to share actual personal problems and issues. Sommers-Flanagan and Means (1987) reported that 15% to 25% of their undergraduate volunteers reported symptoms of psychopathology including depression, suicide ideation, anorexia, bulimia, alcohol/drug abuse, sexual abuse, generalized anxiety, and marital/interpersonal conflicts. These students would need counselors with more training and experience than would be found in first-year graduate students.

Caveats that surface when undergraduates serve as clients for student counselors are not found when actors are used as analog clients. Actors are given roles and asked to play characters who differ appreciably from themselves. There are several advantages to this alternative. Beamish and Dalen (1990) used actors in a family counseling course, to portray a family for Master's level counseling students to counsel. They found that students benefitted from the use of actors because they: (a) could practice counseling skills in a "safe setting;" (b) received vicarious training from observing other students' work with the family; and (c) were exposed to actors who often altered their roles, which surprised them and made the experience more true to life. Counseling students did not need to fear retaliation for portraying particularly challenging clients or feel the need to compete with one another at role-play times since actors rather than fellow students portrayed the client who was in this case a family (Anderson, Gundersen, Banken, Halvorson, & Schmutte, 1989). Medical students' interviewing skills have also been more validly and reliably assessed with actors portraying patients (Scott, Donnelly & Hess, 1976). Lane (1988) described an undergraduate psychology course where students counseled client analogs, in this case undergraduate theater majors who were trained to act as clients. Actors can be usefully employed in a variety of training settings and they are particularly valuable when in vivo counseling experiences are offered to beginning graduate counseling students (Levitov, Fall & Jennings, 1999).

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This review of the literature suggests that advantages and disadvantages can be found in the various methods used to provide experiential training to first-year counseling students. It would therefore be helpful to determine which methods various counselor training programs use to provide pre-practicum practical experiences. In particular we were interested in determining how students are exposed to experiential activities and to actual client contact. The results of this survey follow.

The Method

A telephone survey of 71 randomly sampled colleges and universities that offer graduate degrees in community counseling as defined and listed by Hollis and Wantz (1993) was completed between December of 1997 and January of 1998. Thirty-five of the 71 faculty members queried responded to the survey. The faculty member in charge of clinical training was asked an open ended question designed to elicit information regarding the experiential methods used to train counseling students in pre-practicum courses. When the first faculty member listed was not available, a second faculty member was identified and asked to respond.

Results

The question posed to the faculty members surveyed, regarding pre-practicum training, was designed to explore the methods programs utilize to prepare students for clinical work. Table 1 provides a summary of the pre-practicum training methods used at the programs surveyed. Most commonly, students role-played clients with other students. This method was used by 28 schools or 80% of those interviewed. Some professors emphasized that this was a "role-play activity" and instructed the students not to discuss their personal problems. In other programs, students counseled one another using the student client's own issues. Reasons noted for using actual instead of fictitious personal problems included: "the importance of eliciting real emotions" and "that students should not be above self-disclosure." Two respondents suggested that learning about confidentiality early was important for counselors in training and felt that role-play was the most effective way that this could be learned. Eleven faculty members, 31% of those surveyed, stated that counselor trainees were encouraged to disclose actual issues or problems in their role as the client.

Table 1
Training Methods*

Role-play (fictional client)	Role-play (self)	Actual Clients	Actors
28 (80%)	11 (31%)	9 (26%)	1 (3%)

*Note: Programs may employ several different training methods.

In nine programs, 26% of those surveyed, actual clients are used in early counselor training. But most of these programs use volunteer undergraduates who serve as clients. Counseling these clients was strictly supervised. On the other hand, a few respondents felt that many graduate students were already working in the field and were therefore prepared to work with "real clients." This area was most often used in conjunction with other role-play activities with fellow students.

One school interviewed (3%) used actors from their drama department to work with their counseling students. Four faculty members, or 11% of those canvassed, had used actors in the past, either at their current or at a former university. Three faculty members, 9% of those polled, believed that the use of actors in counselor training could be a very valuable training tool, although they were not currently using this training method. Their reasons for not using actors included: the lack of a drama department in their respective universities, difficulty in obtaining university funding/approval, and the possibility that actors might lack "actual or real emotion" since they would be playing a role.

Discussion

The survey results, for the most part, reflect findings suggested in the literature. For example, role-play activities, most often with fellow students followed by undergraduate volunteers and actors serving as pseudo-clients, surfaced as the most popular experiential training method. However, a larger than expected number of institutions (26%) used actual clients very early in counselor training. This finding is somewhat disturbing since novice counselors may need more coursework and experience before providing services to clients.

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Research on the effects of serving as a client for fellow students is needed to guide counselor educators as they decide the most appropriate training methods for their students. While such findings would be especially important in programs where students participate in role-play activities that require them to discuss their personal problems, there are questions about exercises where students are asked to role-play pseudo problems, as well. Unfortunately, this model is widely used with little research support.

Alternatives to the traditional methods of asking students to serve as clients for each other exist and they are worth further exploration. Modeling, prominent in the literature, probably occurs in most programs. Expanded use of this approach may be a useful alternative. Where medical training, for example, capitalizes on student observation of treatment and procedures, counseling students rarely, if ever, see actual counseling sessions. While ethical concerns governing the observation of counseling sessions exist, permission can be appropriately secured thereby allowing students to observe actual sessions. Unfortunately, further research is needed to answer questions concerning the relative merits of modeling compared to role-play activities.

Although using actors to serve as pseudo clients appears to have certain advantages, a reliable source of actors, the time it takes to train and supervise actors and cost deter the use of this method. Further research examining the effect of the counseling experience on the actors and the relative efficacy of this alternative compared with other types of clients and pseudo-clients is suggested. Finally, training by using computer programs, not found at any of the institutions surveyed, bears further study.

Counselor education programs should consider the relative merits and risks of various experiential modalities as they refine curriculum offerings and strive to train counselors in the most appropriate and effective ways. While the results of this survey indicate that role-play with other students, a mainstay in counselor training, persists as the method of choice, alternatives should be explored. By examining methods of using analogue clients, the joint benefit of giving students counseling experiences while allowing them to simultaneously explore personal issues that need to be resolved in order to become a counselor does not have to be sacrificed. Programs could offer students counseling settings where they could explore these important personal issues separate and distinct from their experiential counselor training with clients and pseudo-clients.

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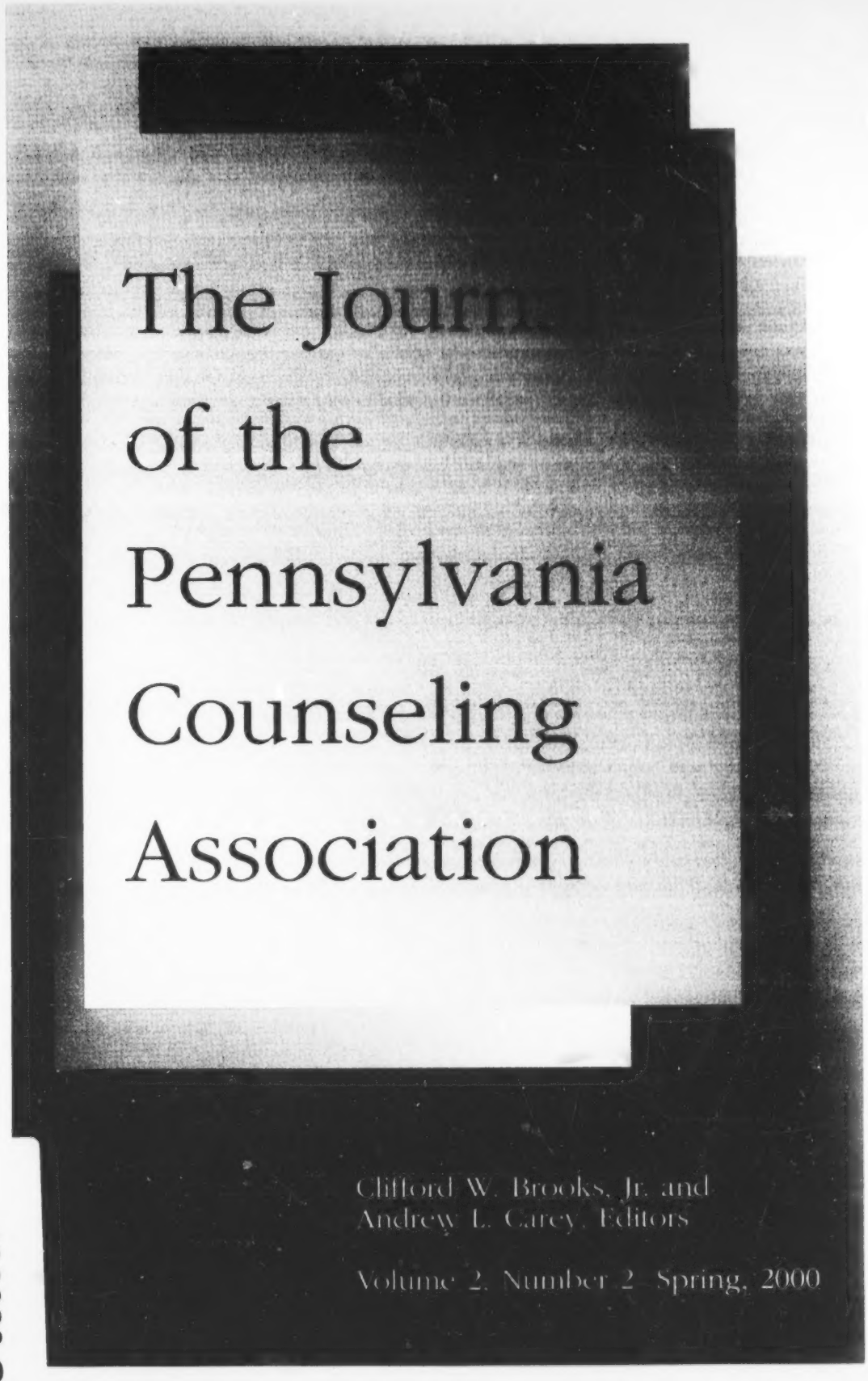
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Recommendations and perspectives from the editors of JPCA are provided for prospective authors to increase opportunities for successful publication.

Much has been written on the subject of publishing within the American Counseling Association and its affiliates. Articles are available on who most publishes (Weinrach, Lustig, Chan, & Thomas, 1998), how to view and approach publishing at a general level (Smaby & Crews, 1998), publishing in ACA branch journals (McGowan, 1994), and practical strategies of selecting a topic and researching and writing on that topic (McGowan, 1994; McGowan, 1996; McGowan, 1997).

Our own reason for writing about publishing is to help you to contribute specifically to JPCA. We believe, as the literature indicates (Smaby & Crews, 1998), that your efforts in submitting manuscripts will be fruitful whether or not your manuscript is "successful" the first time. Not only will your efforts further your own growth, but they will contribute to the growth and direction of the profession, at the very least, through stimulating further thoughts and questions for reviewers and ourselves as editors to consider. Therefore, we encourage you to participate in the direction and growth of JPCA and our counseling associations. To help you in this endeavor, we present very specific, practical recommendations to increase your chances of submitting manuscripts that successfully undergo the review process.

Recommendation 1: Choose a Topic of Interest to JPCA Readers

As co-editors of JPCA, we look for articles that are practical and have clinical application to the field of counseling. Many of our submissions to JPCA, however, are from counselor educators. Few are from full-time practitioners. Therefore, we encourage counselors and counselor educators

alike to submit manuscripts that are of practical importance to Pennsylvania counselors and the field in general. Areas of particular interest to Pennsylvania counselors include school, mental health, rehabilitation, college, and career counseling to name a few. Also appropriate are topics such as *group counseling*, multicultural counseling, and infusing spirituality into the counseling process. If you are more empirically minded, JPCA offers opportunities for both qualitative and quantitative research as well as in-the-field studies.

Beyond wanting a clinical or practical emphasis, we seek articles that fill a need in the literature. When choosing a topic, look for trends and gaps in the literature, both regionally and nationally. Each year brings new approaches and ideas that fill therapeutic gaps in the literature. Manuscripts that help professional counselors increase their learning and develop a current literature base for clinical practice are very valuable to our readers.

Once you decide upon a topic area, choose a specific angle from which to approach that topic. Frequently, this specific angle should be at the edge or boundary of the topic area you wish to address (Schoenfeld & Magnan, 1992), thus adding to the body of current literature. Heppner, Kivlighan, and Wampold (1992) also state, "....it is essential to focus on investigation of just a few constructs, and not to do too much in developing an ....original contribution." Most often our knowledge bases in counseling increase in small steps by building only slightly on previous research" (p. 34). Likewise, McGowan (1996) states, "It is essential that researchers investigate areas that are relevant to the counseling profession and human development, that are not over-researched, that are limited in scope, and are actually researchable" (p. 10).

Recommendation 2: Conduct a Literature Review

Before you begin writing on your topic, conduct a literature review to see if a gap or need truly exists in the literature. This step is important because it will determine the significance, or lack thereof, of your proposed manuscript. When you search the literature on the topic, use various terms, not just the ones you've typically used to discuss the topic. We have found, that frequently, more research and literature has addressed the topic than we knew, primarily because of our unique way of categorizing or discussing the topic. For instance, when one of the authors previously approached writing an article on boundaries and survivors of abuse, he found very little research literature on boundaries at that time. As he checked further after finding, and then using, the word "revictimization," an

enormous body of research and literature emerged. Finding that critical body of research was essential to a fuller and more accurate understanding of the topic, which in turn, was essential for being able to extend that topic significantly for the field of counseling.

Upon finding the available, related literature on your topic, you may find that your approach to the topic is significant or that you need to readjust your focus to find an angle or edge of the topic that does contribute significantly to the existing literature. Revise your angle or focus as needed. Some of your angle will depend upon the terminology most used in the literature. We have found ourselves occasionally trying to explain concepts to others via our own terminology, only to find later that others could not fully comprehend what we presented. As such, it is necessary to begin with terminology already presented and known in the field.

One other consideration before actually beginning to write is building a knowledge base and bigger picture of the topic to be addressed. As you search the literature, you will begin to see themes. When particular themes seem to demand more of your attention, look for how other related literature may connect to or fall under those themes. You will find that much of the related literature will gradually fall under several themes. As those themes further develop, a structure and order to your manuscript will emerge. It's almost as if an outline or bigger picture shows itself to you. If a bigger picture and flow for your manuscript doesn't present itself in this fashion, talking aloud with a colleague about those themes almost immediately brings clarity.

Recommendation 3: Bring Focus and Clarity to Your Writing

One final check before you begin writing: check to see if you can say succinctly what the gap or need is in the literature or field. Also, check to see if you can explain clearly what you are uniquely contributing to the field.

Just like in counseling clients, with no clear problem identification and no clear goal, clear direction is unlikely. Know clearly what the problem or gap is connected to your topic, and know clearly and specifically what you uniquely want to say and who you want to say it to. For your particular manuscript, you may want to speak most to counselor educators. For another manuscript, you may most want to speak to school counselors, rehabilitation counselors, or maybe general practitioners in the field about practical skills that apply to various groups. Once you have clarity about the problem, what you want to say, and who you want to say it to, clearer direction for writing occurs.

Focus and clarity can also come through having a title and abstract that captures the essence of your message. While some writers feel unable to write accurate or effective titles and abstracts until after they've written the body of the manuscript, we encourage you to write one as best as you can up front, and then if it isn't exactly what you need, you can adjust it later. Write a title and abstract that communicate your core message, and then use them as a guide for cohesively writing the rest of your manuscript. Everything you write should tie into and support your main message. As we mentioned earlier, the literature indicates that, too often, writers try to say and accomplish too much in a single manuscript. Therefore, make sure that your title and abstract bring focus to the edge or boundary of the topic you are intending to extend.

For writing the body of your manuscript, follow your thematic structure that arose from the literature review. Also, follow the principle of what we describe as, "meet and extend." As in counseling and teaching, the principle of meet and extend is critical to writing as well. In counseling, the counselor meets the client in the world that the client understands, and then extends incrementally, or developmentally, upon that world. In teaching, the teacher meets the student in the world that the student understands, and then extends upon that world. So too, in writing, the writer meets the reader in the world that the reader understands, and then extends upon that world. For example, does your title and abstract communicate in terminology that professionals in the field already understand? Are you writing the body of your manuscript beginning with concepts that are already described in the literature, and then extending slightly into new concepts that add meaning to professionals' currently existing world? Even from paragraph to paragraph, do you start with a point that makes sense to the reader and then stay with that focus only extending it slightly within that paragraph?

Upon completing your manuscript, check to see that your title, abstract, and subheadings are appropriate and effective for maintaining unity and cohesiveness in your message. You may see a need to rename the manuscript, to rewrite the abstract, or to rename/reorganize subheadings and sections. Also, you may see a need to rewrite most of the manuscript. Occasionally, we have needed to rewrite entire manuscripts in our own process of publishing articles. While rewriting an entire manuscript can be frustrating and disillusioning, that process is typically the most helpful in becoming more proficient at writing.

Recommendation 4: Format and Manuscript Preparation for Mailing

Manuscript format and preparation is critical to a good first impression. Many times, when we review manuscripts to send to reviewers, we are amazed at

how many authors have not followed the APA (1994) format guidelines. When APA format is not followed, we, as well as the reviewers, find it difficult to read the content objectively when poor formatting, missing abstracts, or reference inaccuracies exist. Therefore, we ask that you familiarize yourself with APA format standards to ensure the best opportunity possible for publication.

Also important is following the author guidelines as delineated inside the back cover of JPCA, as well as sending an introductory letter with the appropriate contact information for us to return the manuscript for possible revision. We have received articles with only one manuscript copy (three are needed), sometimes with no cover letter, and occasionally with only an article and the author's name and address on the outside envelope.

Query emails or letters about whether or not your manuscript is suitable for JPCA are minimally helpful when we do not have your manuscript in hand. We suggest that you submit the manuscript and let the review process take its course. Following the submission we will send you a letter of receipt and a time line of when to expect a decision on the manuscript.

Prior to sending us your manuscript, it is helpful to ask two or three readers competent in APA and article writing to evaluate the manuscript. Then after revising based upon their comments and corrections and doing a final check, send three copies of the final manuscript, a cover letter with email and mailing addresses, along with the appropriate postage to JPCA for review.

Concluding comments

Learning to write for publication can be very rewarding. It is fulfilling to see your ideas impacting and making a difference in the field. Even the process of conducting a literature search and submitting manuscripts to JPCA will bring much growth professionally, to you and to JPCA's review team. However, this process will not be without its frustrations and growth pains. Expect that you will not write "the perfect article that will blow away the profession," but instead, that through cuts and bumps you can persevere such that a satisfying product eventually results.

In conclusion, we want you the reader to find JPCA interesting and thought provoking. We seek manuscripts that extend the field either through issues and ideas on the edge of the literature, research studies with solid methodology, and especially through practical concepts that facilitate growth and effectiveness

within practitioners in their unique settings. Appealing both to the practitioner and the counselor educator, we look forward to manuscript submissions that stimulate the heart of Pennsylvania counselors and add to a growing body of knowledge on contemporary issues.

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Ethics, Philosophy, and Culture: Exploring the Issues Involved in the Spirituality-Religion-Counseling Debate

Lance Evans

In the current postmodern culture, counselors are increasingly being called to acknowledge and address client issues of spirituality and religion. Not surprisingly, this call has stimulated passionate debate among counseling professionals. The author demonstrates that this debate invites counselors to thoughtfully analyze the ethical, philosophical, and cultural factors that shape and give meaning to the constructs of spirituality and religion.

According to recent Gallup poll data, religion and spirituality have an influential role in the lives of many Americans, with over 90% reporting they pray, 95% claiming a belief in God, 66% reporting that religion can answer all or most of today's problems, and 58% stating that religion is very important in their lives (The Gallup Organization, 1999). While the effects of religious and spiritual beliefs on psychological well-being have been argued for many years and from numerous perspectives, several researchers (e.g., Bergin, 1980; Bergin, 1983; Bergin, 1988; Bergin, 1991; Duckro, Busch, McLaughlin, & Schroeder, 1992; Richards & Bergin, 1997) have suggested that religion and spirituality are important aspects of human identity that have a significant impact on mental health. Perhaps as a reflection of these data, many in the counseling profession (e.g., Burke et al., 1999; Cornett, 1998; Dishington, 1996; Genia, 1995; Hinterkopf, 1997; Ingersoll, 1994; Kelly, 1995; G. Miller, 1999; W. R. Miller, 1999; Moon, 1997; Porter, 1995; Richards & Bergin, 1997; Shafranske, 1996a) are increasingly calling for counselors to acknowledge and address religion and spirituality as relevant aspects of clients' identities. Not surprisingly, this call has stimulated passionate debate among counseling professionals (see, for example, Bart, 1998).

Although there exists multiple perspectives from which to explore the substance of this debate, a counselor's decision to explore or not explore client issues of religion and spirituality ultimately requires thoughtful analysis in three main areas: ethics, philosophy, and culture. In addition, because ethics, philosophy, and culture are inextricably linked together (Christopher, 1996; Prilleltensky, 1997), any analysis of one dimension of the spirituality-religion-counseling debate (e.g., the ethical dimension) necessarily leads to another dimension (e.g., the philosophical dimension). Therefore, my intent in this article is threefold. First, I will explore the ethical issue of competency as it pertains to counselors working with client issues of spirituality and religion. Second, I will investigate the philosophical question of spirituality and religion as relevant aspects of client identity. Finally, I will explore modernism and postmodernism as cultural contexts that influence the spirituality-religion-counseling debate.

Religion and Spirituality Defined

"Spirituality" and "religion" are terms whose definitions have changed over the course of history. As a result, the literature reflects many definitions for spirituality and religion (Zinnbauer et al., 1997). However, the current literature on spirituality and religion reflects a general consensus on late 20th century definitions of these terms. As Grimm (1994) notes, "spirituality refers to a personal inclination or desire for a relationship with the transcendent or God; religion refers to the social or organized means by which persons express spirituality" (p. 154). Collectively, and for the purposes of this article, these two terms are distinguished from other more commonly accepted aspects of client identity by their unique subjective nature.

The Ethical Issue of Competency

When discussing the concerns that frame the spirituality-religion-counseling debate, the initial and most easily identifiable issue to emerge is the competency question (Yarhouse & Van Orman, 1999). Competency is an ethical issue that surfaces when counselors are confronted with client concerns that fall outside the bounds of their training or experience. The ethical codes and, in fact, most state codes are clear on this issue: counselors must not practice outside the limits of their competency. Consider, for example, the American Counseling Association's (ACA,1995) ethical standards on competency: "Counselors practice only within the boundaries of their

competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience" (Section C.2.a).

Data from recent surveys (Kelly, 1994; Kelly, 1997; Pate & High, 1995; Shafranske & Malony, 1990) indicate that most counseling professionals receive little or no formal training in the area of client issues of spirituality and religion. Accordingly, it should come as no surprise that most counselors enter the spirituality-religion-counseling debate focusing on the competency question. Although it represents only a portion of the debate, this question has merit for very practical reasons: ethical guidelines require counselors who intend to address client religious and spiritual issues to be competent to do so.

That counselors are currently being called to address an aspect of clients for which they most probably have no formal training or experience is an important point of consideration for two reasons. First, the call presents counselors with an ethical dilemma. If counselors choose to answer the call and address client religious and spiritual issues absent any formal training, they do so at the risk of violating an ethical or legal code. On the other hand, if counselors choose to dismiss the call, they have overtly chosen to ignore what the Gallup polls indicate is an important aspect of many individuals' lives.

Second, the call exposes the fact that counselors will only resolve the ethical dilemma by first answering the deeper and more philosophical question that underlies the spirituality-religion-counseling debate: Are spirituality and religion relevant aspects of client identity? If spirituality and religion can legitimately be claimed as relevant aspects of client identity, then counselors should receive formal training in these areas just as they currently receive training in other commonly accepted aspects of client identity (e.g., ethnicity, gender, socioeconomic status, affect, or cognitive ability). Under this scenario, the ethical question of competency becomes less of an issue as it is addressed through education and training. However, if spirituality and religion can not legitimately be claimed as relevant aspects of client identity, then the ethical question of competency is irrelevant; counselors would have no professional reason to be competent in an area that is outside the scope of the counseling profession. Thus, to answer the competency question, it is incumbent upon counselors to investigate the plausibility of spirituality and religion as relevant aspects of client identity.

The Philosophical Question of Relevancy

The history of the mental health professions teaches two important lessons to counselors. First, no theory of mental health escapes its milieu. Consider, for example, the evolutionary process of the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994), whose revisions through the years reflect as much about culture as they do about scientific and clinical advances in mental disorders.

Second, questions concerning mental health are answered in the context of the culture in which they are asked. For example, consider the question, "What causes depression?" Answered in the cultural context of a psychiatric ward in a large hospital, one might receive answers such as, "a neurotransmitter disorder" or "learned helplessness." However, if this question were answered in the cultural context of a pastoral counseling office located in a rural community, one might receive answers such as, "a sinful nature" or "lack of discipline."

How, one might ask, can two cultural contexts have so much influence so as to yield such disparate answers? The answer lies in the assumptions that each culture makes about the nature of the human condition. While the above examples obviously reflect my personal biases about psychiatric wards and pastoral counseling offices, the point to be made here is that a culture is inextricably linked to the foundational assumptions that support that culture. Therefore, in order to answer the philosophical question in the spirituality-religion-counseling debate are spirituality and religion relevant aspects of an individual's identity?...counselors must have knowledge about the cultural context in which the philosophical question is asked. To accomplish this task, it is necessary to examine the two dominant cultural contexts that have defined the 20th century: modernism and postmodernism.

Modernism and Postmodernism as Cultural Contexts

Much has been written over the past decade about modern and postmodern culture. However, many counselors have only a cursory understanding of what the terms mean, much less an appreciation for the way modernism and postmodernism have influenced the counseling profession. Although a thorough exploration of modernism and postmodernism is beyond the scope of this paper (for a more comprehensive analysis of the influence of modernism and postmodernism on the counseling profession, see Sexton & Griffin, 1997), a basic understanding of modern and postmodern culture and

the assumptions that support them is needed in order to answer the philosophical question in the spirituality-religion-counseling debate.

Modernism and postmodernism can be conceptualized as cultural time periods in history. During these cultural time periods, certain assumptions are so embedded in the culture that individuals living in these time periods rarely question the veracity of the assumptions; as such, without necessarily thinking about it, individuals living in these cultural time periods take the assumptions to be true and incorporate them into their worldview. As Longman (1998) states: "We breathe culture like we do air, often not even aware of it. We do not question the air we breathe, so culture [and its assumptions are]...often imbibed without reflection" (p. 23). As a result, everything that is produced by the individuals living in these cultural time periods (e.g., theories about life, the universe, or the human condition) necessarily reflects the embedded assumptions (Fraser & Campolo, 1992; Richards & Bergin, 1997; Schaeffer, 1976).

Modernism as a cultural time period is thought to have begun around the middle of the 18th century. As with any cultural time period, modernism was set in motion by multiple social, economic, political, and religious factors. These factors helped shape a set of assumptions that would dominate culture for the next 200 years. The main assumption that supports modernism is the belief that science, reason, and empiricism can systematically "unlock the secrets of the universe [and bring]...rational management...to human existence" (Grenz, 1996, p. 3). Reflecting these assumptions, modernism is marked by its commitment to rational thinking and reductionism; a belief in absolute "truths;" a belief in the ability to be dispassionately objective; and acceptance of explanations for the mysteries of life in exclusively secular terms (Grenz, 1996; Ingram, 1997; Schaeffer, 1976). Although its momentum has been diminishing since the 1970s, to say that modernism as a cultural time period is completely over is premature. On the contrary, individuals living in the latter half of the 20th century are still heavily influenced by the assumptions of modernism. However, a powerful new cultural time period has emerged... postmodernism...with it own set of embedded assumptions.

It is generally agreed that sometime in the 1970s, a major shift in culture occurred, thus signifying the dawn of the current postmodern culture. As with modernism, the postmodern cultural time period began as a result of multiple factors. In simple terms, the main assumption that supports postmodernism is the belief that modernism's fundamental assumptions are

incorrect; that is, postmodernism denies the ability of science, reason, and empiricism to systematically unlock the secrets of the universe (Grenz, 1996; Ingram, 1997). This is so because postmodernism rejects the modern notion that humans are capable of dispassionate objectivity; on the contrary, postmodernism asserts that humans individually construct their reality and make meaning based on their subjective experiences. Thus, postmodernism is marked by its commitment to relativistic thinking, constructivism, a belief that all "truths" are relative, and multiple interpretations of reality and the mysteries of life. Although relatively young in terms of cultural time periods, postmodernism has eclipsed modernism as the dominant culture of the late 20th century (Grenz, 1996).

When asked in the context of the current postmodern culture, the answer to the philosophical question (are spirituality and religion relevant aspects of an individual's identity?) yields a qualified "yes." Yes, because the possibility exists; qualified, however, because the notion of relevancy in postmodern culture is dependent on the individual. Conversely, in the context of a modern culture, the answer to the philosophical question is a resounding "no." No, because spirituality and religion represent aspects of humanity that are not "ultimately reducible to quantitative terms and [aspects of humanity that are] not clearly anchored therein are frivolous and wasteful or, at best, highly suspect" (Ingram, 1997, p. 315).

Discussion

That the cultural contexts of modernism and postmodernism yield disparate answers to the philosophical question highlights an important feature of the spirituality-religion-counseling debate: the disparate answers reflect the substance of the opposing viewpoints in the debate. As evidence of this statement, consider the following two observations.

The Counseling Profession in Historical Context

The profession of counseling was established in the modern era. As a result, many of modernism's secular assumptions (i.e., anti-spirituality or anti-religious assumptions) are deeply embedded in the counseling profession (Bergin, 1980; Bergin, 1988; Dishington, 1996; Ingram, 1997; Richards & Bergin, 1997). Dishington (1996) summarizes modernism's unfavorable view of spirituality and religion in her description of the legacy left by one of modern psychology's (the precursor to counseling) most influential members:

> Sigmund Freud is widely acknowledged as having popularized psychology at the turn of the present century. He is less often acknowledged as having turned many against religion. Hart (1994) describes Freud as seeing religion and spirituality as the "enemy," an immature form of neurosis, and, a creation of the human mind under the pressure of infantile needs that had no place in the scientific world of adult rationality. (p. 101)

The present day implications for this legacy are potent. Consider, for example, that counseling theory has been taught and practiced for years based on modern assumptions that did not, as noted above, view spirituality and religion kindly. As Bart (1998) demonstrates in a present day article on spirituality and religion, this legacy has proven remarkably strong in the counseling profession:

> In a recent post to the International Counselor Network (ICN) listserv, a counselor simply stated that "religion has no place in counseling." Another recalled a fellow counselor educator standing up in a meeting and declaring that it was time to help clients "get past all of this religious garbage." This particular counselor educator believed that clients need to start taking responsibility for themselves instead of relying on "fictitious gods." (p. 1)

Given modernism's formidable legacy in the counseling profession, it is not surprising that postmodernism's "open arms" acceptance of spirituality and religion is problematic for some counselors.

The Presence of a Debate

The existence of a spirituality-religion-counseling debate is evidence of postmodern culture's influence on the counseling profession. One need only go back several decades to find a point in time (i.e., a point in time when modernism was the dominant culture) when such a debate would not have been entertained (or worse yet, ridiculed). Presently, however, the current postmodern culture has made it possible to not only entertain the debate but also, to think in categories much broader than modernism would ever allow. As a result, everything is possible...including, much to the chagrin of modern culture, irrational (sic) notions such as spirituality and religion as relevant aspects of an individual's identity.

Conclusions and Recommendations

The current postmodern culture has opened the door to a multitude of personal realities. As a result, many in the counseling profession are claiming spirituality and religion as relevant aspects of client identity. Is this claim legitimate? Should client issues of spirituality and religion be addressed in counseling? As demonstrated in this article, the answer to these questions are found by thoughtfully analyzing the ethical, philosophical, and cultural factors that shape and give meaning to the constructs of spirituality and religion. However, it is important to note that as counselors prepare themselves for the new millenium and the increasingly postmodern culture, the counseling profession as a whole has already accepted as relevant other subjective aspects of client identity (e.g., ethnic experiences). As such, it seems inconsistent for counselors to deny the relevancy of spirituality and religion in client identity. Therefore, inasmuch as they bear a responsibility to recognize the culture in which they operate and provide services in light of it, counselors and counselor educators should give strong consideration to the following recommendations.

First, counselors are encouraged to consider including client issues of religion and spirituality as part of their therapeutic encounters. Many excellent resources are available for counselors who want to increase their competency in this area. For example, a recent review of the literature reveals that there is a plethora of publications that deal with the integration of spirituality, religion, and counseling (e.g., Cornett, 1998; Dishington, 1996; Genia, 1995; Hinterkopf, 1997; Ingersoll, 1994; Kelly, 1995; G. Miller, 1999; W. R. Miller, 1999; Moon, 1997; Porter, 1995; Richards & Bergin, 1997; Shafranske, 1996b) and the psychology of religion (e.g., Hood, 1995; Hood, Spilka, Hunsberger, & Gorsuch, 1996; Pargament, 1997; Schoenfeld, 1993). In addition, counselors can find a wealth of information on spiritual and religious issues in counseling and world religions through a variety of other sources such as workshops, university classes, and internet web sites.

Second, counselor educators should give strong consideration to incorporating spirituality and religion into their training programs. Recently, Burke et al. (1999) have suggested that this can be accomplished by including spiritual and religious issues at appropriate points in the eight Council for Accreditation of Counseling and Related Educational Programs (CACREP) common-core areas of study set forth in the Accreditation Standards and Procedures Manual (CACREP, 1994). In addition, other authors (e.g., Richards & Bergin, 1997; Shafranske & Malony, 1996b) have provided training models that could be used as a framework for incorporating spirituality and religion into counselor training.

In the early 1990s, Miranti and Burke (1992) foretold of a coming decade in which counselors would increasingly be challenged to address client issues of spirituality and religion. Given the profusion of spirituality-religion-counseling literature and resources that have emerged in the last eight years, it appears that their prediction had merit. As such, members of the counseling profession be they private practitioners, educators, students, or leaders in state and national organizations can no longer afford to focus their energy and efforts in perpetuating a spirituality-religion-counseling debate. Instead, counseling professionals need to mount a sustained effort to better understand the influence of spirituality and religion on client identity and psychological well-being. It is hoped that the tripartite analysis provided in this article will help counseling professionals begin such an effort.

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Assisting Clients in the Cross-Cultural Adjustment of Counseling

John McCarthy

This article proposes that counseling can be seen as a culture, and, as a result, many clients entering the counseling process experience a kind of cross-cultural adjustment. Counselors can be sensitive to this process, and, by doing so, may aid in the decrease of premature termination. The Storti (1990) model of cross-cultural adjustment is applied to new clients entering counseling, and three methods of helping them to bridge the cross-cultural adjustment to counseling are outlined. They include professional disclosure statements, role induction, and motivational interviewing.

Introduction

This article addresses the socialization of clients to counseling from a cross-cultural perspective and proposes that the counseling process can benefit by aiding clients in this adjustment. First, it highlights the challenge of premature termination. Second, the Storti (1990) model of cross-cultural adjustment is outlined and proposed as a possible explanation in the rates of premature termination. Third, ways to aid clients in the adjustment are described.

It is important to describe terms at the outset of this article. Though "cross-cultural" and "multicultural" are frequently used in the counseling literature, few authors provide an operational definition of them. Stadler, Middleton, and King (1999) offered a set of definitions of diversity-related concepts. They viewed multiculturalism in the counseling setting as "the existence of a prevailing (dominant) environment originating from effective intra and intercultural exchanges" (p. 122). In regard to cross-cultural counseling, Sue, Bernier, Duran, Feinberg, Pedersen, Smith, and Vasquez-Nuttall (1982) claimed that it represented "any counseling relationship in which two or more of the participants differ with respect to cultural background,

values, and lifestyle" (p. 47). For the purpose of this paper, "cross-cultural" describes a person's movement from one distinct or non-distinct culture to another that is more distinct. More specifically, it depicts a person going from a culture not related to counseling to the culture of counseling, with the idea in mind that this cross-cultural movement is more significant when it has not been done before.

The challenge: Premature termination

The definition of premature termination can be viewed from at least two perspectives. The first, as defined by Smith, Subich, and Kalodner (1995), focuses on the number of sessions completed. They saw premature termination as "the client's unilateral withdrawal from treatment after one session" (p. 34). Ward (1984), on the other hand, urged counselors to consider the extent to which the client accomplished the goals set at the outset as well as overall functioning. Regardless of the perspective, premature termination has been perceived as a negative event in counseling (Mennicke, Lent, & Burgoyne, 1988). It has been associated with less therapeutic progress (Robbins, Mullinson, Boggs, Riedesel, & Jacobson, 1985) and increased distress (Phillips & DePalma, 1983, cited in Mennicke et al., 1988). As a result, some clients seek counseling with other professionals (Christensen, Birk, & Sedlacek, 1977). From counselors' viewpoints, clients who schedule a second session and do not keep it represent time that could be devoted to other clients (Rapaport, Roldolfa, & Lee, 1985).

Martin, McNair, and Hight (1988) examined contributing factors to premature termination with college students. Their review of the literature summarized that some counselors were more effective than others in getting clients to return for subsequent sessions and that agreement between client and counselor on the presenting problem is important in decreasing premature termination. In their study on clients who terminated prematurely, they found that most did so due to lack of time for subsequent sessions, the belief that additional sessions were not warranted, or simply forgetting their appointments. Further, they pointed out that their results were consistent with others studies associated with premature termination in the counseling process. After reviewing the literature on premature termination, Walitzer, Dermen, and Connors (1999) concluded that the rates of premature termination are high, suggesting that professionals may not be meeting the initial needs of clients, and that several consistent factors exist for early client dropout.

The entering client and cross-cultural adjustment

One possible factor involved in premature termination is the lack of assistance given to clients in making a smooth transition into the counseling realm. As with many other systems, the counseling profession represents a culture, "any group of people who identify or associate with one another on the basis of some common purpose, need, or similarity of background" (Axelson, 1993, p.3). The notion that counseling represents a distinct culture has received recent support. P. Pedersen (personal communication, February 18, 2000) maintained that "counseling does indeed describe a 'culture' in the broad definition of culture which is gaining popularity." Cheung (2000) reiterated this theme in saying that, similar to all other behaviors, counseling occurs in a cultural context.

The values connected to counseling or any culture arise from the sociocultural foundations on which it was developed. Sue and Sue (1999) outlined several factors within the European-American culture that have influenced the values within the counseling culture. First, the system has been conceptualized in individualistic/idiocentric terms whereby the person is the primary focus. The family and the larger community play only a minor role in many counseling theories. Second, the counseling culture borrows values from the middle- and upper-middle socioeconomic classes in this country. They referred to Schofield's (1964) YAVIS (young, attractive, verbal, intelligent, social) acronym, which indicated that clients with these qualities tended to have a more successful outcome in counseling.

Third, other characteristics of counseling include verbal communication, openness/intimacy, insight, emotional and behavioral expressiveness, and ambiguity. Clients are expected to speak about the more intimate parts of their lives. Those who fail to do so may be labeled as resistant or defensive. The therapeutic situation is ambiguous in that sessions are "unstructured" and make the client be the more active participant (Sue & Sue, 1999,).

In coming into counseling, clients inherently enter the counseling culture with its corresponding values. Clients also bring with them a multitude of their own personal cultures. It would stand that some values of the client would match those of the counseling culture and that others may clash. In most cases of cross-cultural adjustment, the person entering the "new" culture must adapt to the expectations, norms, and values. In counseling, this means

that clients often have to learn the "way" of counseling. The prejudices and misconceptions that clients, consciously and unconsciously, bring to sessions may be influenced by a host of factors.

Besides the media, other factors often influence the accuracy or inaccuracy of the preconceived notions. These can include previous counseling experiences as well as the counseling experiences of others. Prejudices and preconceived notions aside, many people entering the counseling process simply do not know the process, procedures, expectations, norms, and values of the culture. How and where they learn these items can be integral to a successful counseling process as well as a means by which to decrease premature termination.

The Storti model: Understanding adjustment

Designed for individuals preparing to live in a different country, Storti's (1990) model aids in conceptualizing the difficulty that some people encounter in living and working abroad. Premature return rates for many Americans are considerable, and the cost to the company or organization that has sent them overseas can also be considerable. Kohls (1984) speculated that the chances of an American having a successful experience abroad was about one in seven.

The process of cross-cultural adjustment is essential in both adapting to life in another country and to successfully entering the counseling culture. In the former, sojourners may return home if adjustment is not successful. In the latter, clients may leave counseling, resulting in premature termination. Storti's (1990) model offers two kinds of adjustment: "Type I," in which the persons entering the new culture have to adjust their behavior to fit the native culture, which is something that "annoys, confuses, or unsettles" them (p. 15). Conversely, "Type II" incidents occur when the entering persons behave in ways that offend the individuals in the native culture. In counseling, "Type I" incidents are often a part of the initial phase in that the client has to learn--and in some ways adapt to--the expectations, norms, and values of the counseling culture.

People have expectations upon entering cultures different than their own. Often unconscious, the expectation is commonly that the members will be similar to them (and their personal cultures). In reality, however, this is most often not the case. At some point in the early stages of adjustment, a "cultural incident" occurs. This generally shakes the pre-existing expectations

and causes an agitation. The affective reaction of fear, anxiety, and/or anger provides newcomers with a choice point: They can either withdraw or become aware of the process. By choosing the latter option, people may reflect upon the cause of the agitation and subsequently observe other situations, through which culturally realistic expectations can be developed (Storti, 1990).

Clients do bring expectations to counseling, and, when their expectations conflict with what takes place (a "cultural incident"), they may psychologically withdraw (a type of resistance) or physically withdraw (prematurely terminate) from the counseling process. As Sue and Sue (1999) pointed out, "Misunderstandings that arise from cultural variations in communication may lead to alienation and/or inability to develop trust and rapport" (p. 58).

Helping the client adjust

Ivey and Ivey (1999) maintained that "structuring" and "mutual goal setting" are the two most important parts of the initial interview, for they provide a common understanding between the client and counselor about what will happen in counseling and the nature of the desired goals. Both provide a basis from which trust and helping can take place. Furthermore, they warned that an absence of these two qualities can lead to such detriments as malpractice suits, some of which arise from failure-to-treat issues. Many such issues arise when counselors and clients "have only vague ideas about what is to happen in counseling and what counseling can actually accomplish" (p. 173).

The remainder of this article focuses on "pretraining," the goal of which is "to educate the client about the counseling process or to enhance his or her expectations" (Mennicke et al., 1988, p. 459). The methods discussed here are in no way intended to be exhaustive, but are set forth to help practitioners to understand potential additional ways to assist clients in the cross-cultural change process. They include professional disclosure statements, role induction, and motivational interviewing.

Professional disclosure statements provide a welcome to clients in explaining the background, theoretical orientation, and general expectations of counseling. Its importance is critical in understanding the counseling culture, for the statement covers many items that can facilitate the cross-cultural entry into counseling. As Keel and Brown (1999) pointed out, "With more than 100

theoretical orientations and schools of thought, the consumers of our services can be easily confused with jargon, titles, credentials, and initials which we so freely toss around" (p. 14). Furthermore, such statements offer potential clients additional information from which they can decide whether a particular counselor may be right for them. Counselors are ethically mandated to inform clients and potential clients of the purposes and goals of the counseling process (ACA, 1995).

Professional disclosure statements are a part of role induction, another way to socialize clients' expectations of them within counseling (Beutler & Clarkin, 1990). According to Nelson and Neufeldt (1996), role induction can avoid what Storti (1990) called a "cultural incident," which can cause a person to withdraw from the culture. Instead they maintained that such an induction can empower clients to "anticipate what will happen in a situation that may be highly foreign and potentially frightening" (p. 612). Done before therapy begins, this educational process has been empirically supported for its value, suggesting that role induction increases retention rates (Wilson, 1985); aids in positive perceptions of counseling (Zwick & Attkisson, 1985); facilitates treatment compliance (Zwick & Attkisson, 1985); and enhances therapeutic outcome (Zwick & Attkisson, 1985). Beutler and Clarkin (1990) broke down role induction into three areas: (a) instructional methods (explaining counseling expectations to clients); (b) observational and participatory learning (modeling and practice prior to therapy); and (c) treatment contracting (oftentimes signed agreements). Along with clients' informed consent, role induction can decrease misunderstanding and confusion that can get in the way of therapeutic progress (Nelson & Neufeldt, 1996).

Walitzer et al. (1999) offered an excellent discussion of treatment preparation strategies, one of which was motivational interviewing (Miller & Rollnick, 1991). Entering a new culture such as counseling may affect a client's motivational level, and a lack of motivation is a frequently given reason offered in premature termination. In some cases an absence of motivation has been labeled as "resistance." Carr (Marino, 1995) summarized resistance that fits with cross-cultural entry in saying, "I change this [the connotation of resistance] to perceive the client as doing something they want to do...I perceive resistance as a client's way of letting me know what they are prepared to do and not prepared to do" (p. 8).

The ambivalence to change is central to motivational interviewing, defined as "a directive, client-centered counselling style for eliciting behaviour

change by helping clients to explore and resolve ambivalence" (Rollnick & Miller, 1995). Examining and resolving ambivalence represents a primary goal of motivational interviewing, and it is done by way of such elements as counselor empathy, developing discrepancy, avoiding argumentation, rolling with resistance, and supporting self-efficacy in enhancing clients' motivation (Miller & Rollnick, 1991). The counselor elicits and reinforces reasons for change from the client, while at the same time maintaining a warm, supportive environment in exploring the ambivalence (Miller, 1996). After reviewing the empirical studies on motivational interviewing to date, Rollnick and Miller (1995) claimed that "reasonable support" existed for the efficacy of it in sparking behavior change, particularly among individuals with alcohol-related problems (p. 331).

Conclusion

As might be expected, clients who enter counseling with positive expectations have higher levels of involvement than those who bring negative expectations with them (Tinsley, Tokar, & Helwig, 1994). Behind positive expectations may be previous positive experiences in counseling, hope that the decision to enter counseling will lessen the presenting problem, or positive experiences of a friend or relative who has had counseling. What may be more important to study, however, are the factors--negative, neutral, and positive--behind expectations that some clients bring to counseling. In regard to those that are negative, a part of these perceptions may result in emotions of confusion and anxiety upon entering the counseling culture. Given the Storti (1990) model of cross-cultural adjustment, it is conceivable that clients may withdraw when their expectations are not realized, thereby resulting in premature termination. The methods described--professional disclosure statements, role induction, and motivational interviewing--ease cross-cultural adjustment into counseling by clearly delineating the values, process, and expectations of the counseling culture as well as of the counselor. Further, attempts to heighten client motivation during beginning stages of counseling may also facilitate the adjustment into the helping culture.

It is interesting to note that, while attention to multicultural counseling has increased during the present decade, the attention devoted to premature termination appears to have decreased. This article attempts to link the two together with the underlying hypothesis that increased sensitivity to clients' cross-cultural adjustment into counseling may decrease their rates of premature termination. Instead of viewing dropout as solely under the clients' realm, it is

important to note that counselors can have some determination in this process as well. This alternative view is echoed in Walitzer et al. (1999), as they reminded, "...therapists can have a great impact on whether their clients remain in treatment" (p. 147). The cost of assistance in cross-cultural adjustment in the form of preparatory and motivational interventions is minimal, and clients are likely to welcome such interventions. Further, studies have found that they can increase client retention and participation (Walitzer et al., 1999). As Storti (1990) noted, "Perhaps the most obvious consequence of successful [cross-cultural] adjustment is that we foreigners become increasingly effective in our work" (p. 92). With some assistance from the counselor, the same notion may apply to clients in the counseling process.

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Measuring Counselor Development with the Counselor Self-Efficacy Scale

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The purpose of this study was to determine if counseling self-efficacy is a multidimensional construct and whether it varies as a function of counseling experience, theoretical orientation and type of graduate training program. The results indicated that the CSES measures three constructs (Group Counseling Efficacy, Clinical Skills Efficacy and Interpersonal Skills Efficacy). Higher self-efficacy expectations were associated with greater counseling experience. In addition, counseling psychology students and individuals with a psychodynamic theoretical orientation exhibited greater group counseling self-efficacy. Implications for counselor educators are discussed.

Models of counselor development and supervision have received a great deal of attention in the research literature over the past decade. Proponents of these models maintain that trainees progress through a series of developmental stages emerging into mature, competent counselors (Hogan, 1964; Littrell, Lee-Borden, & Lorenz, 1979; Loganbill, Hardy, & Delworth, 1982; Stoltenberg, 1981; Stoltenberg & Delworth, 1987). However, there is no consensus regarding the form of these developmental levels in trainees. For example, Stoltenberg (1981) and Hogan (1964) propose a four stage model of trainee development while Stoltenberg and Delworth (1987) propose a three stage model, and much of the research has supported the presence of a two stage model (Miars, Tracey, Ray, Cornfeld, O'Farrell, & Gelso, 1983; Reising & Daniels, 1983; Wiley & Ray, 1986). Such discrepancies raise questions regarding which conceptualization of counselor development and supervision reflects the true state of affairs.

Despite the fact that differences exist among the models, their basic premise is the same - trainees evolve from neophytes with limited skills

and insight to seasoned helping professionals who have developed a broad repertoire of counseling skills that are employed with a more complex understanding of client dynamics and the counseling process. Given that researchers have expended a great deal of effort on delineating the characteristics of trainees across experience levels, it seems that the next logical step is to determine what factors keep them moving along the developmental continuum. Indeed, in order for a comprehensive theory of counselor development to be advanced, it is important to identify the underlying components common to all models that help trainees develop into competent helping professionals. One purpose of this study was to examine how counseling self-efficacy could be such a component.

Self-Efficacy Theory

Self-efficacy theory is based on the notion that peoples' beliefs in their ability to perform certain behaviors successfully is an important mediator of behavior change (Bandura, 1982). This is clearly applicable to all models of counselor development as trainees continually grapple with issues of competence and self-confidence regarding various counseling activities (Loganbill et al., 1982). The central constructs of self-efficacy theory are outcome expectations and efficacy expectations. An outcome expectation represents "...a person's estimate that a given behavior will lead to a certain outcome" (Bandura, 1977, p. 193). An efficacy expectation, on the other hand, "...is the conviction that one can successfully execute the behavior required to produce the outcomes" (Bandura, 1977, p. 193). Outcome and efficacy expectations are differentiated because people may believe a certain action will result in a particular outcome but doubt their ability to engender the outcome. Thus, beginning trainees may understand that paraphrasing and reflection are important skills to facilitate a counseling session but feel uncertain about their ability to manifest these skills competently.

Research has been conducted in this area which provides initial evidence for self-efficacy theory as it applies to counselor development. Johnson, Baker, Kopala, Kiselica, and Thompson (1989) found that counselor trainees who were involved in a master's-level prepracticum course perceived counseling self-efficacy to increase over the course of a semester. Sipps, Sugden, and Favier (1988) examined how self-efficacy varied by experience level and found that third and fourth year graduate students possessed stronger self-efficacy beliefs than first or second year graduate students. Likewise Larson, Suzuki, Gillespie, Potenza, Bechtel,

and Toulouse (1992) found that counselor trainees enrolled in a prepracticum course scored significantly lower on a measure of counseling self-efficacy than either master's-level counselors or doctoral-level counseling psychologists. It would be premature to conclude, however, that counseling self-efficacy increases incrementally as one gains experience. Indeed, Friedlander and Snyder (1983) did not report any differences between beginning master's level counseling students, doctoral students and interns with regard to self-efficacy.

Melchert, Hays, Wiljanen, and Kolocek (1996) investigated changes in self-efficacy across four levels of training (1st year master's student, 2nd year master's student, 3rd - 6th year doctoral student, professional doctoral level psychologists) so as to provide more specific information as to how and when changes in self-efficacy occur. They developed the Counseling Self-Efficacy Scale (CSES) for use in this study because there were no other instruments available at the time that were intended for use with this broad of range of trainees. As expected, they found that counseling self-efficacy increased significantly as trainees gained experience in the field. However, the implications of these findings for developmental models of counseling were limited by the sample which was drawn from a counseling psychology program at one university and included a small number of doctoral level psychologists. In addition, the CSES only yielded a global self-efficacy score despite the fact that previous research has indicated that counselor self-efficacy may be multidimensional (Larson et al., 1992). Indeed, Leach, Stoltenberg, McNeill, and Eichenfield (1997), using a self-efficacy instrument designed by Larson (1992), found in a study with a group of counseling students that counseling self-efficacy is a multidimensional factor characterized by microskills, the counseling process, difficult client behaviors, cultural competence, and awareness of values. However, this study did not provide detailed evidence about differences in self-efficacy relating to developmental level as only two broad developmental levels were compared.

The present study addresses the aforementioned limitations by (1) determining whether counselor self-efficacy, as measured by the CSES, is multidimensional via factor analysis and (2) investigating how self-efficacy varies across training and experience levels using a broader sample of trainees and clinicians from various training programs and work settings across the United States. Two other variables, theoretical orientation and type of training degree program, were examined to determine what

specific factors are related to counseling self-efficacy. Given the fact that training in theories of counseling is an integral part of all counseling-related programs, it would be illuminating to find out if this is related to counseling self-efficacy and, if so, whether one particular theory contributes more to counseling self-efficacy than others. In addition, discovering whether some training programs do a better job at helping trainees feel confident about their ability to engage in counseling activities could be important in helping individuals decide which training programs to pursue. This particular study focuses on APA-accredited counseling and clinical psychology programs, and compares and contrasts the findings with the research literature on, and nature of, CACREP accredited counseling programs. Implications for CACREP-accredited counseling programs are then discussed.

Method

Participants

There were a total of 108 participants in the current study which included 84 counseling trainees affiliated with graduate programs in APA-accredited counseling psychology (n = 36) and clinical psychology (n = 48) programs and 24 doctoral level psychologists, 75% of whom worked in a private practice setting. Twenty-nine percent of the trainees were participating in a beginning practicum (0 - 1 completed semesters of practicum), 38% in an advanced practicum (2 or more completed semesters of practicum and not yet a pre-doctoral intern) while the remainder (33%) were participating in a pre-doctoral internship (a one year training experience completed at the end of a doctoral program). Participants were located in 28 states and Washington D.C. The ages of the participants ranged from 22 to 66 (M = 33.61, SD = 9.78); 70% were female. Individuals from various ethnic backgrounds were represented (White, 83%; Hispanic, 6%; Asian American, 5%; African American, 4%; Other, 2%).

Procedure

One hundred eighty training directors from APA-accredited counseling and clinical psychology programs and internship sites were contacted by letter and informed of the nature and purpose of the study. They were asked to distribute test materials (consisting of a cover letter describing the nature and purpose of the study, a demographic information form and the CSES) to two students affiliated with their training programs. Training directors were asked to choose the students randomly so there

would be a better chance that the most "typical" student was represented in the study. The completed questionnaires were then returned to the investigator in self-addressed stamped envelopes provided to the training directors. Reminder letters were sent to the training directors two weeks after the initial mailing. Only those training directors who originally agreed to participate in the study were instructed to place letters in the mailboxes of trainees.

In addition to the trainees, 50 doctoral-level psychologists who were listed in the National Register of Health Service Providers in Psychology were randomly chosen for inclusion in the study. They were likewise contacted by letter requesting their participation in the study.

Participation in the study was completely voluntary on the parts of training directors, trainees, and psychologists, and anonymity and confidentiality were insured. Eighty-four trainees from 56 training programs and twenty-four psychologists participated by returning completed questionnaires reflecting a 26% response rate.

Instrument

The Counselor Self-Efficacy Scale (CSES) consists of 20 items designed to assess one's perceived level of knowledge and skill pertaining to individual and group therapy and professional counseling activities. Melchert et al. (1996) constructed the questionnaire by including areas of knowledge and skill competencies that are deemed important to counsel competently regardless of theoretical orientation as outlined by experts in the literature. It is important to note, however, that Melchert et al. did not determine empirically that the CSES is unrelated to counselor theoretical orientation. Items were included on the final version of the questionnaire only if all four authors of the Melchert study agreed that the items met the aforementioned criteria.

Respondents are requested to read each item and indicate to what extent they agree with the statement by using a 5-point rating scale (1 = Agree strongly, 5 = Disagree strongly). Half of the items are worded negatively to avoid acquiescent response bias. Scoring consists of summing the ratings and dividing by the total number of items.

The reliability of the CSES was assessed using two different methods - internal consistency and test-retest. The internal consistency of

the instrument (using Cronbach's alpha) was .91 while the test-retest reliability coefficient was .85 based on two administrations of the CSES with a 1-week interval (Melchert et al., 1996).

The content validity of the CSES was evaluated by having three licensed psychologists read each item and determine whether or not the item measured some aspect of counseling self-efficacy. The expert psychologists unanimously agreed that 19 of the 20 items reflected this construct (Melchert et al., 1996). The convergent validity of the CSES was demonstrated by its high correlation (.83) with the Self-Efficacy Inventory (Friedlander & Snyder, 1983), a similar questionnaire which measures trainees' perceptions of counseling knowledge and skill competencies.

A demographic questionnaire was also administered which included items assessing the participants' training experience level, number of clients counseled per week, and number of months/years of full-time, professional (i.e., paid, non-practica or internship-related) counseling experience.

Results

Factor Analysis of Items on the CSES

The items on the CSES were subjected to exploratory factor analysis using the squared multiple correlations on the main diagonal followed by varimax rotation. Exploratory factor analysis was used instead of confirmatory factor analysis because it was unclear how the items were related to one another on an a priori basis. Using the criteria of the scree test, interpretability and eigenvalues greater than 1, a three factor solution was judged best in accounting for variation in the data. The three factors accounted for 52% of the variance. Using items with loadings greater than .40, a simple structure was approximated. The factor loadings and item-scale correlations of the items are reported in Table 1.

Factor 1 accounted for 19% of the known variance. The 5 items that loaded highly on this factor are reflective of one's knowledge and skills relating to group counseling (e.g., "I can function effectively as a group leader/facilitator."). As such, this factor was labeled "Group Counseling Efficacy" (M = 19.46, SD = 4.39). Factor 2 accounted for 18% of the known variance. The 7 items that loaded highly on this factor assess one's knowledge and skills relating to therapy, diagnosis/assessment and

Table 1

Factor Loadings and Item-Scale Correlations of Items on the CSES

Factor and item	Factor 1	Factor 2	Factor 3	I-S*
Factor 1: Group Counseling Efficacy				
16. I am familiar with the advantages and disadvantages of group counseling as a form of intervention.	.79	.22	.13	.83
17. My knowledge of the principles of group dynamics is not adequate.	.78	.10	.32	.84
18. I am able to recognize the facilitative and debilitative behavior of group members.	.78	.14	.00	.77
19. I am not familiar with the ethical and professional issues specific to group work.	.77	.23	.11	.81
20. I can function effectively as a group leader/facilitator.	.76	.13	.23	.82
Factor 2: Clinical Skills Efficacy				
1. My knowledge of personality development is adequate for counseling effectively.	.24	.76	.19	.80
3. My knowledge of behavior change principles is not adequate.	.09	.72	.23	.70
4. I am not able to perform psychological assessment to professional standards.	-.05	.65	-.08	.49
5. I am able to recognize major psychiatric conditions.	.24	.58	.17	.72
6. My knowledge regarding crisis intervention in not adequate.	.29	.54	.29	.72
9. I am not able to accurately identify client affect.	.37	.53	.30	.70
14. I am not able to apply behavior change skills effectively.	.10	.40	.14	.54
Factor 3: Interpersonal Skills Efficacy				
7. I am able to effectively develop therapeutic relationships with clients.	-.05	.20	.82	.72
8. I can effectively facilitate client self-exploration.	.10	.29	.75	.77
11. I am not able to accurately identify my own emotional reactions to clients.	.23	-.05	.63	.63
12. I am not able to conceptualize client cases to form clinical hypotheses.	.30	.30	.48	.62
15. I am able to keep my personal issues from negatively affecting my counseling.				

*I-S - Item-Scale Correlation

personality ("My knowledge of personality development is adequate for counseling effectively."). This factor was subsequently designated "Clinical Skills Efficacy" (M = 29.05, SD = 4.58). Factor 3 accounted for 15% of the known variance. The 5 items that loaded highly on this factor represent one's ability to establish therapeutic relationships and identify personal factors affecting the therapeutic process ("I am able to keep my personal issues from negatively affecting my counseling."). This factor was entitled "Interpersonal Skills Efficacy" (M = 22.69, SD = 2.26).

Intercorrelations of the CSES Scales

The three scales of the CSES were moderately correlated (Group Counseling Efficacy and Clinical Skills Efficacy, r = .49; Group Counseling Efficacy and Interpersonal Skills Efficacy, r = .48; Clinical Skills Efficacy and Interpersonal Skills Efficacy, r = .57). The magnitude of these relationships is about the same as that found in other factor analytic studies measuring similar dimensions. Despite the fact that these scales are related, they are not so strongly correlated so as to preclude researchers and supervisors from using them to identify distinct areas of efficacy.

Reliability

The reliability of the CSES factor scales was assessed using Cronbach's alpha. The alpha coefficients of the Group Counseling Efficacy, Clinical Skills Efficacy, and Interpersonal Skills Efficacy scales were .88, .81, and .73 respectively. These results are encouraging as Nunnally (1967) maintains that psychological tests should have internal consistency reliability estimates of at least .70. It is apparent, then, that the scales contain items which consistently tap common dimensions respective to each scale.

Relationship of CSES to Participant Training and Experience Level

Prior to data analysis, the negatively worded items on the CSES were reverse scored such that higher scores on the instrument were reflective of stronger counseling self-efficacy. Means and standard deviations of CSES scores by participant training level are reported in Table 2.

One-factor ANOVAs were conducted on each of the scales to determine whether or not CSES scores varied according to the training level

Table 2

Means and Standard Deviations of CSES Scores by Participant Training Level and Post-hoc Comparisons

	Participant Training Level				
	Group 1 Beginning Practicum Student	**Group 2** Advanced Practicum Student	**Group 3** Predoctoral Intern	**Group 4** Doctoral Level Psychologist	Significantly Different Groups
Group Counseling Efficacy	15.95 (4.00)	18.34 (4.51)	21.53 (2.94)	22.04 (3.05)	2 > 1; 3 > 1 & 2; 4 > 1 & 2
Clinical Skills Efficacy	24.58 (4.53)	28.43 (3.73)	30.71 (3.73)	32.41 (2.35)	2 > 1; 3 > 1 & 2; 4 > 1 & 2
Interpersonal Skills Efficacy	21.04 (3.05)	22.78 (1.73)	23.25 (1.81)	23.58 (1.61)	2 > 1; 3 > 1; 4 > 1

Note: Beginning practicum student (n = 24); Advanced practicum student (n = 32); Pre-doctoral intern (n = 28); Doctoral-level psychologist (n = 24). Only those comparisons which resulted in significant differences between groups at the $p < .05$ level are reported.

of the participants. As expected, the CSES scores varied significantly by training level on the Group Counseling Efficacy, $F(3, 109) = 13.89$, $p < .0001$, Clinical Skills Efficacy, $F(3, 109) = 20.49$, $p < .0001$ and Interpersonal Skills Efficacy scales, $F(3, 109) = 7.10$, $p < .0001$. In general, those at more advanced training levels (including doctoral-level psychologists) demonstrated greater levels of self-efficacy in all three areas. However, it should be noted that there were no significant differences between pre-doctoral interns and doctoral-level psychologists on any of the scales which may indicate that counseling self-efficacy reaches a plateau at a certain stage of training. One other finding which bears noting is that there were no significant differences between the advanced practicum students, pre-doctoral interns and the doctoral-level psychologists on the Interpersonal Skills Efficacy scale. It is possible that supervisors spend

more time stressing the development of these skills beginning in the advanced practicum and continue to focus on this aspect of counselor training during the pre-doctoral internship (see Miars et al., 1983) such that there are no significant shifts in perceived self-efficacy at these two levels of training.

Given that some participants in a training program may had been performing counseling work for some time prior to their enrolling in the program, one-factor ANOVAs were conducted on each of the scales to determine whether or not CSES scores varied according to the experience level of the participants. Three categories of experience level were developed in a similar manner to those in the Melchert et al. (1996) study. However, fewer and larger groupings were constructed in the present study given that small cell sizes in certain experience categories would have been statistically prohibitive. Preliminary analyses conducted on the CSES indicated that significant differences occurred between participants with no counseling experience, 1 month - 4 years of experience and 5 and more years of experience. Means and standard deviations of CSES scores by participant experience level are reported in Table 3.

As with the training level of participants, differences were found based on experience level on the three scales ($F(2, 110) = 10.00$, $p < .0001$; $F(2, 110) = 21.42$, $p < .0001$; $F(2, 110) = 8.82$, $p < .0001$, respectively). Once again, participants with greater amounts of counseling experience had higher efficacy scores in all three areas.

Relationship of CSES to Participant Theoretical Orientation and Degree Program

Two other variables which were investigated concerned how counseling self-efficacy related to participants' theoretical orientations and the type of degree program they were participating in for their professional training. Means and standard deviations of CSES scores by participant theoretical orientation and degree program are reported in Table 4.

Because the experience level of the participants was found to be an important variable in perceived levels of counseling self-efficacy, I used analysis of covariance (ANCOVA), with experience level serving as the covariate, to control for this influence. One-factor ANCOVAs were conducted on each of the scales to determine whether CSES scores varied according to the theoretical orientation of the participants. The CSES scores

Table 3

Means and Standard Deviations of CSES Scores by Participant Experience Level and Post-hoc Comparisons

	Participant Experience Level			
	No Counseling Experience	1 Month - 4 Years Counseling Experience	5 - 20 Years Counseling Experience	Significantly Different Groups
Group Counseling Efficacy	17.95 (4.23)	19.18 (4.68)	22.17 (2.91)	3 > 1 & 2
Clinical Skills Efficacy	26.60 (4.82)	29.54 (3.72)	32.37 (2.35)	2 > 1; 3 > 1 & 2
Interpersonal Skills Efficacy	21.84 (2.66)	22.87 (1.69)	23.82 (1.55)	2 > 1; 3 > 1

Note: No counseling experience (n = 46); 1 month - 4 years counseling experience (n = 33); 5 - 20 years counseling experience (n = 29). Only those comparisons which resulted in significant differences between groups at the $p < .05$ level are reported.

varied significantly by theoretical orientation on the Group Counseling Efficacy scale only, $F(2, 107) = 4.65$, $p < .01$. Those participants with a psychodynamic orientation scored higher on this scale than participants with cognitive-behavioral and eclectic orientations.

The degree program of the participants was also examined as it relates to counseling self-efficacy. One factor ANCOVAs revealed significant differences between those in counseling psychology and clinical psychology programs on the Group Counseling Efficacy and Interpersonal Skills Efficacy scales ($F(1, 106) = 10.03$, $p < .01$; $F(1, 106) = 8.50$, $p < .01$, respectively). Specifically, participants in counseling psychology-training

Table 4

Means and Standard Deviations of CSES Scores by Participant Theoretical Orientation and Degree Program

	Scale					
	Group Counseling Efficacy		Clinical Skills Efficacy		Interpersonal Skills Efficacy	
Theoretical Orientation	M	SD	M	SD	M	SD
Psychodynamic (n = 20)	22.40	(3.08)	30.80	(3.57)	23.95	(1.27)
Cognitive-Behavioral (n = 30)	19.06	(3.92)	30.16	(3.39)	22.50	(1.83)
Eclectic (n = 58)	18.65	(4.63)	27.87	(5.11)	22.36	(2.59)
Degree Program						
Counseling Psychology (n = 44)	20.72	(4.05)	29.11	(4.62)	23.36	(1.76)
Clinical Psychology (n = 64)	18.59	(4.43)	29.01	(4.59)	22.23	(2.46)

programs had greater confidence in their ability to facilitate groups and to establish and facilitate therapeutic relationships in comparison to those in clinical psychology training programs.

Discussion

The purpose of this study was to determine whether counselor self-efficacy, as measured by the CSES, is a multidimensional construct and whether self-efficacy varies across training and experience levels using a broader sample of trainees and clinicians from various training programs and work settings across the United States. Other variables were also examined (e.g., theoretical orientation, degree program) to determine their relationship to counseling self-efficacy.

The results of the factor analysis of CSES ratings indicate that the instrument measures three constructs related to counseling self-efficacy (Group Counseling Efficacy, Clinical Skills Efficacy, and Interpersonal Skills Efficacy). The scales of the CSES are highly reliable although they are

moderately correlated with one another, reflecting an underlying general construct of counseling self-efficacy. The findings of this study are consistent with the results of the Melchert et al. (1996) study in that counselors with different levels of experience perceive themselves as possessing varying amounts of counseling self-efficacy. However, more specific information was delineated from the present study by virtue of determining the factor structure of the CSES and examining how counselors-in-training and psychologists rated themselves on the three factors. In particular, beginning practicum students do not possess a great deal of confidence in their counseling skills or ability to conceptualize what occurs in counseling. Advanced practicum students demonstrated greater perceived confidence and competence while pre-doctoral interns and doctoral-level psychologists demonstrated the highest degree of counseling self-efficacy (save for the Interpersonal Skills Efficacy scale where advanced practicum, pre-doctoral interns and doctoral-level psychologists scored in a similar range).

In general, a gradual increase in counseling self-efficacy occurs as one progresses through a degree program. Confidence is more than likely a by-product of competencies gained throughout the course of training by virtue of practicing a behavior repeatedly. Thus, confidence increases as one accumulates and benefits from personal mastery experiences. In self-efficacy terms, trainees develop and master basic counseling skills resulting in a belief that they can execute an increasing number of behaviors necessary to produce the desired outcomes. Indeed, Loganbill et al. (1982) state: "The basic theme of competence is one that is returned to in a recycling process again and again as the counselor develops throughout the professional life span. If the counselor persistently pursues development along this theme, a wider range of skills become available and more choices arise, thus increasing the level of competence and the ability to carry through the conceptual plan. Issues of competence thus become important underlying ones for all others" (p. 20). Thus, counseling self-efficacy may be an important underlying component of other developmental milestones.

Not only did counseling self-efficacy vary by training level, but differences were also evident based on participants' theoretical orientations and type of degree program. Individuals with a psychodynamic theoretical orientation manifested greater levels of confidence regarding their ability to facilitate groups. This is in contrast to Larson et al.'s (1992) study assessing counselors and counseling psychologists which did not find differences

among counseling self-efficacy scores across three theoretical orientations, although they did not include individuals with a psychodynamic orientation nor was group counseling self-efficacy one of the factors that was assessed. It is not entirely clear why individuals with a psychodynamic theoretical orientation feel more confident in this area. Perhaps because individuals with this perspective tend to place a great deal of emphasis on how interpersonal relationships shape a person's interactions with others, they may perceive group counseling as the natural complement to their orientation because participants learn about dynamics which underlie their relationship styles. This, in turn, may translate into feelings of confidence about their ability to conduct group counseling.

It is apparent, however, that those with a psychodynamic and cognitive-behavioral orientation feel equally confident to perform traditional clinical functions such as diagnosis and treatment. This may be reflective of similarities in training requirements of APA-accredited training programs which is where the bulk of the sample for this study was obtained. It is possible that if a sample of counselor education students who typically receive less training on diagnosis and evaluation had been included in the sample, they would have scored lower in this area. However, it is equally conceivable that counselor education students would have felt more confident than their counseling "cousins" in areas which have been strong areas of emphasis from a counseling perspective (e.g., human development). Thus, counseling self-efficacy is obviously affected by training focus. As such, the CSES could potentially be used by counselor educators as a measurement device to assess their students' progress in areas where they are expected to exhibit increasingly higher levels of confidence (i.e., group counseling and interpersonal relationship skills).

What is interesting to note is that those trained in a counseling and clinical psychology training program displayed differences in certain areas despite standardization in program requirements. Participants in counseling psychology programs felt more confident about facilitating groups and facilitating therapeutic relationships in comparison to those in clinical psychology programs. Counseling psychology programs have traditionally incorporated group counseling as a core component of their training experiences for students and perhaps this is reflected in participants' perceptions of skills in this area. In addition, there has been less of an emphasis on diagnosis and evaluation and more of an emphasis

on relationship issues in counseling psychology programs which may account for differences between counseling and clinical psychology subjects. This is consistent with students in CACREP-accredited counselor education programs who, as part of their training, receive training in core areas including group counseling and helping relationships primarily from a normal, developmental perspective.

This study improves upon many of the weaknesses of the Melchert et al. (1996) study. In particular, the sample was based on trainees from both APA-accredited counseling and clinical psychology programs across the United States. In addition, the size of the professional psychologist group was larger and permitted stronger inferences about the results. Future research should include a sample of counselor education students to examine similarities and differences in self-efficacy across disciplines. This is an important step to take so as to begin identifying key factors that contribute to self-efficacy among all helping professionals. Also, the information that is gleaned from such a study would help determine whether the CSES would be a useful evaluation tool to measure progress in counselor education students.

A number of weaknesses were evident in this study. First, the response rate (26%) was low thus limiting the extent to which one can make confident conclusions about the data. Secondly, approximately three-quarters of the sample were women who were predominately white. As such, caution is warranted in generalizing these results to men and other ethnic groups. Finally, the research design used in this study does not permit causal interpretations. There are no doubt other factors besides experience level, theoretical orientation and type of degree program which contribute to counseling self-efficacy (e.g., amount/type of supervision) which could be more accurately pinpointed with an experimental design. This information is important to provide more empirical support for developmental models of counselor development and supervision.

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